February 15, 2001

HOUSE BILL No. 1727

DIGEST OF HB 1727 (Updated February 14, 2001 2:32 PM - DI 73)

Citations Affected: IC 4-22; IC 12-7; IC 12-10; IC 12-15; IC 12-16; IC 12-17.6; IC 12-17.7; IC 12-17.8; IC 34-30; IC 35-43; noncode.

Synopsis: Medicaid and uninsured parents program. Establishes the uninsured parent's program (program) within the office of the secretary of family and social services to provide health insurance coverage to certain uninsured individuals. Provides eligibility requirements that an individual must meet in order to enroll in the program. Provides that providers enrolled under the Medicaid program are considered providers for the program. Repeals the hospital care for the indigent program. Provides for funding of the uninsured parents program. Makes changes to the Medicaid disproportionate share hospital payment structure. Requires each nursing home to annually evaluate each patient and provide the information to the office of Medicaid policy and planning (OMPP) and requires OMPP to review evaluations and, if OMPP determines that an individual's needs can be met in a setting other than a nursing home, inform the individual of that determination and the services that are available to allow the individual to reside in a non-nursing home setting. Provides that OMPP may not increase the base amount used for calculation of reimbursement rates for inpatient and outpatient hospital services over the base amount in effect on January 1, 2001. Requires each state department and agency and each local governmental unit to cooperate with OMPP who shall conduct a study to examine means by which to cover Medicaid eligible care provided by the local units with state or local funding. Repeals certain statutes allowing the temporary admission of an Indiana resident to a nursing home without completing a preadmission screening.

Effective: July 1, 2000 (retroactive); January 1, 2001 (retroactive); July 1, 2001; January 1, 2002; June 30, 2002; July 1, 2002; July 1, 2003.

Crawford, Friend, Kuzman

January 17, 2001, read first time and referred to Committee on Ways and Means.
February 14, 2001, amended, reported — Do Pass.

February 15, 2001

First Regular Session 112th General Assembly (2001)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2000 General Assembly.

HOUSE BILL No. 1727

A BILL FOR AN ACT to amend the Indiana Code concerning health and human services and to make an appropriation.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 4-22-2-37.1, AS AMENDED BY P.L.273-1999, SECTION 160, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2002]: Sec. 37.1. (a) This section applies to a rulemaking action resulting in any of the following rules:

(1) An order adopted by the commissioner of the Indiana department of transportation under IC 9-20-1-3(d) or IC 9-21-4-7(a) and designated by the commissioner as an emergency rule.

(2) An action taken by the director of the department of natural resources under IC 14-22-2-6(d) or IC 14-22-6-13.

(3) An emergency temporary standard adopted by the occupational safety standards commission under IC 22-8-1.1-16.1.

(4) An emergency rule adopted by the solid waste management board under IC 13-22-2-3 and classifying a waste as hazardous.

(5) A rule, other than a rule described in subdivision (6), adopted by the department of financial institutions under IC 24-4.5-6-107

and declared necessary to meet an emergency.

(6) A rule required under IC 24-4.5-1-106 that is adopted by the department of financial institutions and declared necessary to meet an emergency under IC 24-4.5-6-107.

(7) A rule adopted by the Indiana utility regulatory commission to address an emergency under IC 8-1-2-113.

(8) An emergency rule jointly adopted by the water pollution control board and the budget agency under IC 13-18-13-18.

(9) An emergency rule adopted by the state lottery commission under IC 4-30-3-9.

(10) A rule adopted under IC 16-19-3-5 that the executive board of the state department of health declares is necessary to meet an emergency.

(11) An emergency rule adopted by the Indiana transportation finance authority under IC 8-21-12.

(12) An emergency rule adopted by the insurance commissioner under IC 27-1-23-7.

(13) An emergency rule adopted by the Indiana horse racing commission under IC 4-31-3-9.

(14) An emergency rule adopted by the air pollution control board, the solid waste management board, or the water pollution control board under IC 13-15-4-10(4) or to comply with a deadline required by federal law, provided:

(A) the variance procedures are included in the rules; and

(B) permits or licenses granted during the period the emergency rule is in effect are reviewed after the emergency rule expires.

(15) An emergency rule adopted by the Indiana election commission under IC 3-6-4.1-14.

(16) An emergency rule adopted by the department of natural resources under IC 14-10-2-5.

(17) An emergency rule adopted by the Indiana gaming commission under IC 4-33-4-2, IC 4-33-4-3, or IC 4-33-4-14.

(18) An emergency rule adopted by the alcoholic beverage commission under IC 7.1-3-17.5, IC 7.1-3-17.7, or IC 7.1-3-20-24.4.

(19) An emergency rule adopted by the department of financial institutions under IC 28-15-11.

(20) An emergency rule adopted by the office of the secretary of family and social services under IC 12-8-1-12.

(21) An emergency rule adopted by the office of the children's health insurance program under IC 12-17.6-2-11.

(22) An emergency rule adopted by the office of the uninsured parents program under IC 12-17.7-2-7.

(b) The following do not apply to rules described in subsection (a):

(1) Sections 24 through 36 of this chapter.

(2) IC 13-14-9.

(c) After a rule described in subsection (a) has been adopted by the agency, the agency shall submit the rule to the publisher for the assignment of a document control number. The agency shall submit the rule in the form required by section 20 of this chapter and with the documents required by section 21 of this chapter. The publisher shall determine the number of copies of the rule and other documents to be submitted under this subsection.

(d) After the document control number has been assigned, the agency shall submit the rule to the secretary of state for filing. The agency shall submit the rule in the form required by section 20 of this chapter and with the documents required by section 21 of this chapter. The secretary of state shall determine the number of copies of the rule and other documents to be submitted under this subsection.

(e) Subject to section 39 of this chapter, the secretary of state shall:

(1) accept the rule for filing; and

(2) file stamp and indicate the date and time that the rule is accepted on every duplicate original copy submitted.

(f) A rule described in subsection (a) takes effect on the latest of the following dates:

(1) The effective date of the statute delegating authority to the agency to adopt the rule.

(2) The date and time that the rule is accepted for filing under subsection (e).

(3) The effective date stated by the adopting agency in the rule.

(4) The date of compliance with every requirement established by law as a prerequisite to the adoption or effectiveness of the rule.

(g) Subject to subsection (h), IC 14-10-2-5, IC 14-22-2-6, and IC 22-8-1.1-16.1, a rule adopted under this section expires not later than ninety (90) days after the rule is accepted for filing under subsection (e). Except for a rule adopted under subsection (a)(14), the rule may be extended by adopting another rule under this section, but only for one (1) extension period. A rule adopted under subsection (a)(14) may be extended for two (2) extension periods. Except for a rule adopted under subsection (a)(14), for a rule adopted under this section to be effective after one (1) extension period, the rule must be adopted under:

(1) sections 24 through 36 of this chapter; or

(2) IC 13-14-9;

as applicable.

(h) A rule described in subsection (a)(6), (a)(9), or (a)(13) expires on the earlier of the following dates:

(1) The expiration date stated by the adopting agency in the rule.

(2) The date that the rule is amended or repealed by a later rule adopted under sections 24 through 36 of this chapter or this section.

~~(h)~~ **(i)** This section may not be used to readopt a rule under IC 4-22-2.5.

SECTION 2. IC 12-7-2-24.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2002]: **Sec. 24.5. "Caretaker relative" for purposes of IC 12-17.7, has the meaning set forth in IC 12-17.7-1-2.**

SECTION 3. IC 12-7-2-52.2, AS ADDED BY P.L.273-1999, SECTION 163, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2002]: Sec. 52.2. **(a)** "Crowd out", for purposes of IC 12-17.6, has the meaning set forth in IC 12-17.6-1-2.

(b) "Crowd out", for purposes of IC 12-17.7, has the meaning set forth in IC 12-17.7-1-2.

SECTION 4. IC 12-7-2-69 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 69. (a) "Division", except as provided in subsections (b) and (c), refers to any of the following:

(1) The division of disability, aging, and rehabilitative services established by IC 12-9-1-1.

(2) The division of family and children established by IC 12-13-1-1.

(3) The division of mental health established by IC 12-21-1-1.

(b) The term refers to the following:

(1) For purposes of the following statutes, the division of disability, aging, and rehabilitative services established by IC 12-9-1-1:

(A) IC 12-9.

(B) IC 12-10.

(C) IC 12-11.

(D) IC 12-12.

(2) For purposes of the following statutes, the division of family and children established by IC 12-13-1-1:

(A) IC 12-13.

(B) IC 12-14.

(C) IC 12-15.

(D) IC 12-16.
(E) **IC 12-16.1.**
(F) IC 12-17.
~~(F)~~ **(G)** IC 12-17.2.
~~(G)~~ **(H)** IC 12-17.4.
~~(H)~~ **(I)** IC 12-18.
~~(I)~~ **(J)** IC 12-19.
~~(J)~~ **(K)** IC 12-20.

(3) For purposes of the following statutes, the division of mental health established by IC 12-21-1-1:
(A) IC 12-21.
(B) IC 12-22.
(C) IC 12-23.
(D) IC 12-25.

(c) With respect to a particular state institution, the term refers to the division whose director has administrative control of and responsibility for the state institution.

(d) For purposes of IC 12-24, IC 12-26, and IC 12-27, the term refers to the division whose director has administrative control of and responsibility for the appropriate state institution.

SECTION 5. IC 12-7-2-76, AS AMENDED BY P.L.128-1999, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: Sec. 76. (a) "Eligible individual", for purposes of IC 12-10-10, has the meaning set forth in IC 12-10-10-4.

(b) "Eligible individual" has the meaning set forth in IC 12-14-18-1.5 for purposes of the following:
(1) IC 12-10-6.
(2) IC 12-14-2.
(3) IC 12-14-18.
(4) IC 12-14-19.
(5) IC 12-15-2.
(6) IC 12-15-3.
~~(7) IC 12-16-3.~~
~~(8)~~ **(7)** IC 12-17-1.
~~(9)~~ **(8)** IC 12-20-5.5.

SECTION 6. IC 12-7-2-76.5, AS AMENDED BY P.L.95-2000, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2002]: Sec. 76.5. (a) "Emergency", for purposes of IC 12-20, means an unpredictable circumstance or a series of unpredictable circumstances that:
(1) place the health or safety of a household or a member of a household in jeopardy; and

(2) cannot be remedied in a timely manner by means other than township assistance.

(b) "Emergency", for purposes of IC 12-17.6 **and IC 12-17.7,** ~~has the meaning set forth in IC 12-17.6-1-2.6.~~ **means a medical condition that manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:**

(1) place an individual's health in serious jeopardy;

(2) result in serious impairment to the individual's bodily functions; or

(3) result in serious dysfunction of a bodily organ or part of the individual.

SECTION 7. IC 12-7-2-104.5, AS ADDED BY P.L.128-1999, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: Sec. 104.5. "Holocaust victim's settlement payment" has the meaning set forth in IC 12-14-18-1.7 for purposes of the following:

(1) IC 12-10-6.

(2) IC 12-14-2

(3) IC 12-14-18.

(4) IC 12-14-19.

(5) IC 12-15-2.

(6) IC 12-15-3.

~~(7) IC 12-16-3.~~

~~(8)~~ **(7)** IC 12-17-1.

~~(9)~~ **(8)** IC 12-20-5.5.

SECTION 8. IC 12-7-2-110, AS AMENDED BY P.L.142-2000, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 110. "Hospital" means the following:

(1) For purposes of IC 12-15-11.5, the meaning set forth in IC 12-15-11.5-1.

(2) For purposes of IC 12-15-18, the meaning set forth in IC 12-15-18-2.

(3) For purposes of ~~IC 12-16, except IC 12-16-1,~~ **IC 12-16.1,** the term refers to a hospital licensed under IC 16-21.

SECTION 9. IC 12-7-2-118.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: **Sec. 118.1. "Inpatient days", for purposes of IC 12-16.1-8, has the meaning set forth in IC 12-16.1-8-1.**

SECTION 10. IC 12-7-2-131.3 IS ADDED TO THE INDIANA

CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 131.3. "Minimum data set", for purposes of IC 12-15-41, has the meaning set forth in IC 12-15-41-1.**

SECTION 11. IC 12-7-2-134, AS AMENDED BY P.L.273-1999, SECTION 165, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2002]: Sec. 134. "Office" means the following:

(1) Except as provided in subdivisions (2) and (3), the office of Medicaid policy and planning established by IC 12-8-6-1.

(2) For purposes of IC 12-10-13, the meaning set forth in IC 12-10-13-4.

(3) For purposes of IC 12-17.6, the meaning set forth in IC 12-17.6-1-4.

(4) For purposes of IC 12-17.7, the meaning set forth in IC 12-17.7-1-3.

SECTION 12. IC 12-7-2-146, AS AMENDED BY P.L.273-1999, SECTION 166, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2002]: Sec. 146. "Program" refers to the following:

(1) For purposes of IC 12-10-7, the adult guardianship services program established by IC 12-10-7-5.

(2) For purposes of IC 12-10-10, the meaning set forth in IC 12-10-10-5.

(3) For purposes of IC 12-17.6, the meaning set forth in IC 12-17.6-1-5.

(4) For purposes of IC 12-17.7, the meaning set forth in IC 12-17.7-1-4.

SECTION 13. IC 12-7-2-149, AS AMENDED BY P.L.14-2000, SECTION 28, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2002]: Sec. 149. "Provider" means the following:

(1) For purposes of IC 12-10-7, the meaning set forth in IC 12-10-7-3.

(2) For purposes of the following statutes, an individual, a partnership, a corporation, or a governmental entity that is enrolled in the Medicaid program under rules adopted under IC 4-22-2 by the office of Medicaid policy and planning:

(A) IC 12-14-1 through IC 12-14-9.5.

(B) IC 12-15, except IC 12-15-32, IC 12-15-33, and IC 12-15-34.

(C) IC 12-17-10.

(D) IC 12-17-11.

(E) IC 12-17.6.

(F) IC 12-17.7.

(3) For purposes of IC 12-17-9, the meaning set forth in IC 12-17-9-2.

(4) For the purposes of IC 12-17.2, a person who operates a child care center or child care home under IC 12-17.2.

(5) For purposes of IC 12-17.4, a person who operates a child caring institution, foster family home, group home, or child placing agency under IC 12-17.4.

SECTION 14. IC 12-7-2-164 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 164. "Resident" has the following meaning:

(1) For purposes of IC 12-10-15, the meaning set forth in IC 12-10-15-5.

(2) For purposes of ~~IC 12-16, except IC 12-16-1,~~ **IC 12-16.1,** an individual who has actually resided in Indiana for at least ninety (90) days.

(3) For purposes of IC 12-20-8, the meaning set forth in IC 12-20-8-1.

(4) For purposes of IC 12-24-5, the meaning set forth in IC 12-24-5-1.

SECTION 15. IC 12-10-12-27 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 27. (a) **Except as provided in subsection (b),** the agency shall, subject to the approval of the division, designate at least one (1) individual who may authorize temporary admittance to a nursing facility under

~~(1) subsection (b); and~~

~~(2)~~ sections 28, 30, and 31 of this chapter

without the approval required under this chapter.

(b) An individual designated under subsection (a) may **not** authorize temporary admittance to a nursing home **under subsection (a)** for a ~~resident~~ **nonresident** of Indiana. ~~if the resident:~~

~~(1) has received treatment from and is being discharged from a hospital that is located in a state other than Indiana; and~~

~~(2) will be participating in preadmission screening under this chapter.~~

~~(c) Notwithstanding a rule adopted under section 12 of this chapter, a screening team appointed to screen a nonresident under this section must:~~

~~(1) conduct its assessment under section 16 of this chapter; and~~

~~(2) report its findings;~~

~~within ten (10) days after its appointment.~~

SECTION 16. IC 12-15-1-16.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 16.5. Each state department or agency and each local governmental unit shall cooperate with the office who shall conduct a study to examine means in which to cover Medicaid eligible care provided by the departments, agencies, or units with state or local funding.**

SECTION 17. IC 12-15-15-1.1, AS AMENDED BY P.L.113-2000, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000 (RETROACTIVE)]: Sec. 1.1. (a) This section applies to a hospital that is:

(1) licensed under IC 16-21; and

(2) established and operated under IC 16-22-2 or IC 16-23.

(b) a state fiscal year ending after June 30, ~~1997,~~ **2000,** in addition to reimbursement received under section 1 of this chapter, a hospital is entitled to reimbursement in an amount calculated ~~from the hospital's cost report filed with the office for the hospital's fiscal period ending during the state fiscal year, equal to the difference between:~~

~~(1) the amount of payments to the hospital under this article, excluding payments under IC 12-15-16 and IC 12-15-19, for services provided by the hospital during the state fiscal year; and~~

~~(2) an amount equal to the lesser of the following:~~

~~(A) The hospital's customary charges for the services described in subdivision (1).~~

~~(B) A reasonable estimate by the office of the amount that must be paid for the services described in subdivision (1) under Medicare payment principles.~~ **as follows:**

STEP ONE: The office shall identify the aggregate services reimbursed under this article provided by hospitals established and operated under IC 16-22-2, IC 16-22-8, and IC 16-23.

STEP TWO: For the aggregated services identified under STEP ONE, the office shall calculate the aggregate payments made under this article to hospitals established and operated under IC 16-22-2, IC 16-22-8, and IC 16-23, excluding payments under IC 12-15-16 and IC 12-15-19.

STEP THREE: For the period beginning January 1, 2001, and ending June 30, 2001, and for a state fiscal year ending after June 30, 2001, the office shall calculate an amount equal to one hundred fifty percent (150%) of a reasonable estimate of the amount that would have been paid in the aggregate by the office for services described in STEP ONE under Medicare

payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: From the amount calculated under STEP FOUR, distribute to a hospital established and operated under IC 16-22-8 an amount equal to one hundred percent (100%) of the difference between:

(A) the aggregate payments for covered services made under this article to the hospital, excluding payments under IC 12-15-16 and IC 12-15-19; and

(B) a reasonable estimate of the amount that would have been paid for the services described in subdivision (1) under Medicare payment principles.

The actual distribution of the amount calculated under this STEP shall be made pursuant to the terms and conditions provided for the hospital in the state plan for medical assistance.

STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.

STEP SEVEN: Distribute an amount equal to the amount calculated under STEP SIX to the eligible hospitals described in subsection (c) in proportion to each hospital's hospital specific limit under 42 U.S.C. 1396r-4(g), as determined by the office.

(c) Subject to subsection (e), reimbursement under this section consists of a single payment made after the close of each state fiscal year. **Payment for a state fiscal year ending after June 30, 2001, shall be made before December 31 following the state fiscal year's end.** A payment described in this subsection is not due to a hospital unless:

(1) the hospital is licensed under IC 16-21 and is established and operated under IC 16-22-2 or IC 16-23; and

(2) an intergovernmental transfer is made under subsection (d).

(d) Subject to subsection (e), a hospital may make an intergovernmental transfer **under this subsection,** or an intergovernmental transfer may be made on behalf of the hospital, after the close of each state fiscal year. An intergovernmental transfer under this subsection shall be made to the Medicaid indigent care trust fund in an amount equal to eighty-five percent (85%) of the amount ~~determined~~ **to be distributed to the hospital** under **STEP FIVE of** subsection (b). The intergovernmental transfer must be used to fund **the state's share of payments under this section and** a portion of the

state's share of disproportionate share payments under IC 12-15-20-2(2), **and payments for the uninsured parents program under IC 12-15-20-2(5).**

(e) ~~An entity~~ **A hospital** making an intergovernmental transfer under subsection (d) may appeal under IC 4-21.5 the amount determined by the office to be paid **the hospital** under **STEP SEVEN of** subsection (b). The periods described in subsections (c) and (d) **for a hospital to make an intergovernmental transfer** are tolled pending the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5.

(f) The office may not implement this section until the federal Health Care Financing Administration has issued its approval of the amended state plan for medical assistance. The office may determine not to continue to implement this section if federal financial participation is not available.

(g) For the state fiscal year beginning July 1, 2000, and ending June 30, 2001, the amount calculated under STEP THREE of subsection (b) shall be adjusted to account for the portion of the state fiscal year prior to the effective date of the federal regulation establishing the Medicaid upper payment limit for non-state government owned or operated hospitals at one hundred fifty percent (150%) of Medicare reimbursement rates.

(h) For purposes of calculating the amount under STEP THREE of subsection (b), the amount attributable to the period of the state fiscal year described in subsection (g) shall be the maximum payment amount available without exceeding the Medicaid upper payment limit applicable for non-state owned or operated hospitals for that period.

SECTION 18. IC 12-15-15-9, AS AMENDED BY P.L.113-2000, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 9. (a) **Subject to subsections (e) and (f),** for each state fiscal year ~~beginning on or after July 1, 1997,~~ **ending June 30, 1998, June 30, 1999, June 30, 2000, June 30, 2001, and June 30, 2002,** a hospital is entitled to a payment under this section.

(b) Total payments to hospitals under this section for a state fiscal year shall be equal to all amounts transferred from the hospital care for the indigent fund for Medicaid current obligations during the state fiscal year, including amounts of the fund appropriated for Medicaid current obligations **and funds available under IC 12-16-14.1-3.**

(c) The payment due to a hospital under this section must be based on a policy developed by the office. The policy:

(1) is not required to provide for equal payments to all hospitals;

(2) must attempt, to the extent practicable as determined by the office, to establish a payment rate that minimizes the difference between the aggregate amount paid under this section to all hospitals in a county for a state fiscal year and the amount of the county's hospital care for the indigent property tax levy for that state fiscal year; and

(3) must provide that no hospital will receive a payment under this section less than the amount the hospital received under IC 12-15-15-8 for the state fiscal year ending June 30, 1997.

(d) Following the transfer of funds under subsection (b), an amount equal to the amount determined in the following STEPS shall be deposited in the Medicaid indigent care trust fund under IC 12-15-20-2(2) and used to fund a portion of the state's share of the disproportionate share payments to providers for the state fiscal year:

STEP ONE: Determine the difference between:

(A) the amount transferred from the state hospital care for the indigent fund under subsection (b); and

(B) thirty-five million dollars ($35,000,000).

STEP TWO: Multiply the amount determined under STEP ONE by the federal medical assistance percentage for the state fiscal year.

(e) If funds are transferred to the Medicaid program under IC 12-16-14.1-2(f), those funds constitute the state's share of funding for payments to hospitals under this subsection. A payment under this subsection shall be made to all hospitals that received a payment under this section for the state fiscal year beginning July 1, 2001, and ending June 30, 2002. Payments under this subsection shall be in proportion to each hospital's payment under this section for the state fiscal year beginning July 1, 2001, and ending June 30, 2002.

(f) If the office of the uninsured parents program established by IC 12-17.7-2-1 does not implement an uninsured parents program before July 1, 2003, a hospital is entitled to a payment under this section for each state fiscal year beginning on or after July 1, 2003.

SECTION 19. IC 12-15-15-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2001 (RETROACTIVE)]: **Sec. 11. Hospitals licensed under IC 16-21 that are established and operated under IC 16-22 or IC 16-23 are nominal charge hospitals for purposes of the Medicaid program.**

SECTION 20. IC 12-15-15-12 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS

[EFFECTIVE JULY 1, 2001]: **Sec. 12. The office may not increase the base amount used to calculate reimbursement rates for inpatient and outpatient hospital services over the base amount used by the office on January 1, 2001.**

SECTION 21. IC 12-15-16-2, AS AMENDED BY P.L.113-2000, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000 (RETROACTIVE)]: Sec. 2. (a) For purposes of disproportionate share eligibility, a provider's Medicaid inpatient utilization rate is a fraction (expressed as a percentage) where:

(1) the numerator is the provider's total number of Medicaid inpatient days in the most recent year for which an audited cost report is on file with the office; and

(2) the denominator is the total number of the provider's inpatient days in the most recent year for which an audited cost report is on file with the office.

(b) For purposes of this section, "**Medicaid** inpatient days" includes **all acute care** days ~~provided by an acute care excluded distinct part subprovider unit of the provider and inpatient days attributable to Medicaid beneficiaries from other states. The term also includes inpatient days attributable to:~~

~~(1) Medicaid managed care recipients; and~~

~~(2) Medicaid eligible patients.~~

attributable to individuals eligible for Medicaid benefits under a state plan approved under 42 U.S.C. 1396a on the days of service:

(1) whether attributable to individuals eligible for Medicaid in Indiana or any other state;

(2) even if the office did not make payment for any services, including inpatient days that are determined to be medically necessary but for which payment is denied by the office for other reasons; and

(3) including days attributable to Medicaid beneficiaries receiving services through a managed care organization or health maintenance organization.

However, a day is not a Medicaid inpatient day for purposes of this section if the patient was entitled to both Medicare Part A, as defined by 42 U.S.C. 1395c, and Medicaid on that day.

SECTION 22. IC 12-15-16-3, AS AMENDED BY P.L.113-2000, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: Sec. 3. (a) For purposes of disproportionate share eligibility, a provider's low income utilization rate is the sum of the following, based on the most recent year for which an audited cost report is on file with the office:

(1) A fraction (expressed as a percentage) for which:
(A) the numerator is the sum of:
(i) the total Medicaid patient revenues paid to the provider; plus
(ii) the amount of the cash subsidies received directly from state and local governments, including payments made under the hospital care for the indigent program (IC 12-16-2) **(before its repeal);** and
(B) the denominator is the total amount of the provider's patient revenues paid to the provider, including cash subsidies; and
(2) A fraction (expressed as a percentage) for which:
(A) the numerator is the total amount of the provider's charges for inpatient services that are attributable to care provided to individuals who have no source of payment; and
(B) the denominator is the total amount of charges for inpatient services.

(b) The numerator in subsection (a)(1)(A) does not include contractual allowances and discounts other than for indigent patients not eligible for Medicaid.

SECTION 23. IC 12-15-19-2.1, AS ADDED BY P.L.113-2000, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000 (RETROACTIVE)]: Sec. 2.1. (a) For each state fiscal year ending on or after June 30, 2000, the office shall develop a disproportionate share payment methodology that ensures that each hospital qualifying for disproportionate share payments under IC 12-15-16-1(a) timely receives total disproportionate share payments that do not exceed the hospital's hospital specific limit provided under 42 U.S.C. 1396r-4(g). The payment methodology as developed by the office must:

(1) maximize disproportionate share hospital payments to qualifying hospitals to the extent practicable;
(2) take into account the situation of those qualifying hospitals that have historically qualified for Medicaid disproportionate share payments; and
(3) ensure that payments net of intergovernmental transfers made by or on behalf of qualifying hospitals are equitable.

(b) Total disproportionate share payments to a hospital under this chapter shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year shall be determined by the office taking into account data provided by each hospital that is considered reliable by the office based on a system

of periodic audits, the use of trending factors, and an appropriate base year determined by the office. The office may require independent certification of data provided by a hospital to determine the hospital's hospital specific limit.

(c) The office shall include a provision in each amendment to the state plan regarding Medicaid disproportionate share payments that the office submits to the federal Health Care Financing Administration that, as provided in 42 CFR 447.297(d)(3), allows the state to make additional disproportionate share expenditures after the end of each federal fiscal year that relate back to a prior federal fiscal year. However, the total disproportionate share payments to:

(1) each individual hospital; and

(2) all qualifying hospitals in the aggregate;

may not exceed the limits provided by federal law and regulation.

(d) The office shall, in each state fiscal year, provide sufficient funds ~~that, when added to the federal medical assistance percentage figure described in 42 U.S.C. 1396d(b), total a minimum of twenty-six million dollars ($26,000,000) as the state's share of Medicaid disproportionate share expenditures~~ for acute care hospitals licensed under IC 16-21 ~~and private psychiatric institutions licensed under IC 12-25~~ that qualify for disproportionate share payments under IC 12-15-16-1(a). **Funds provided under this subsection:**

(1) do not include funds transferred by other governmental units to the Medicaid indigent care trust fund; and

(2) must be in an amount equal to the amount that results from the following calculation:

STEP ONE: Multiply twenty-six million dollars ($26,000,000) by the federal medical assistance percentage.

STEP TWO: Subtract the amount determined under STEP ONE from twenty-six million dollars ($26,000,000).

SECTION 24. IC 12-15-19-10, AS AMENDED BY P.L.113-2000, SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000 (RETROACTIVE)]: Sec. 10. (a) ~~This subsection applies~~ For the state fiscal year beginning July 1, 1999, and ending June 30, 2000, ~~If the state exceeds the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)) or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)),~~ the state shall pay providers as follows:

(1) The state shall make disproportionate share provider payments to municipal disproportionate share providers qualifying under IC 12-15-16-1(b) until the state exceeds the state disproportionate

share allocation ~~The total amount paid to municipal disproportionate share providers under IC 12-15-16-1(b) may not exceed twenty-two million dollars ($22,000,000).~~ **(as defined in 42 U.S.C. 1396r-4(f)(2)).**

(2) After the state makes all payments under subdivision (1), if the state fails to exceed the state disproportionate share allocation **(as defined in 42 U.S.C. 1396r-4(f)(2)), or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)),** the state shall make community mental health center disproportionate share provider payments to providers qualifying under IC 12-15-16-1(c). The total paid to the qualified community mental health center disproportionate share providers under section 9(a) of this chapter, including the amount of expenditures certified as being eligible for federal financial participation under IC 12-15-18-5.1(e), ~~may not exceed~~ **must be at least** six million dollars ($6,000,000).

(3) After the state makes all payments under subdivision (2), if the state fails to exceed the state disproportionate share allocation **(as defined in 42 U.S.C. 1396r-4(f)(2)),** the state shall make disproportionate share provider payments to providers qualifying under IC 12-15-16-1(a).

(b) ~~This subsection applies~~ For state fiscal years beginning after June 30, 2000, ~~If the state exceeds the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)) or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)),~~ the state shall pay providers as follows:

(1) The state shall make **municipal** disproportionate share provider payments to providers qualifying under ~~IC 12-15-16-1(a)~~ **IC 12-15-16-1(b)** until the state exceeds the state disproportionate share allocation **(as defined in 42 U.S.C. 1396r-4(f)(2)).**

(2) After the state makes all payments under subdivision (1), if the state fails to exceed the state disproportionate share allocation **(as defined in 42 U.S.C. 1396r-4(f)(2)),** the state shall make ~~municipal~~ disproportionate share provider payments to providers qualifying under ~~IC 12-15-16-1(b).~~ **IC 12-15-16-1(a).**

(3) After the state makes all payments under subdivision (2), if the state fails to exceed the state disproportionate share allocation **(as defined in 42 U.S.C. 1396r-4(f)(2)), or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)),** the state

shall make community mental health center disproportionate share provider payments to providers qualifying under IC 12-15-16-1(c).

SECTION 25. IC 12-15-20-2, AS AMENDED BY P.L.113-2000, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000 (RETROACTIVE)]: Sec. 2. The Medicaid indigent care trust fund is established to pay the state's share of the following:

(1) Enhanced disproportionate share payments to providers under IC 12-15-19-1.

(2) **Subject to subdivision (5),** disproportionate share payments to providers under IC 12-15-19-2.1.

(3) Medicaid payments for pregnant women described in IC 12-15-2-13 and infants and children described in IC 12-15-2-14.

(4) Municipal disproportionate share payments to providers under IC 12-15-19-8.

(5) Of the intergovernmental transfers deposited into the Medicaid indigent care trust fund under IC 12-15-15-1.1(d), the following apply:

(A) The entirety of the intergovernmental transfers deposited into the Medicaid indigent care trust fund under IC 12-15-15-1.1(d) for the state fiscal years ending on or before June 30, 2000 shall be used to fund the state's share of the disproportionate share payments to providers under IC 12-15-19-2.1.

(B) Of the intergovernmental transfers deposited into the Medicaid indigent care trust fund under IC 12-15-15-1.1(d) for state fiscal years ending after June 30, 2000, an amount equal to one hundred percent (100%) of the total intergovernmental transfers deposited into the Medicaid indigent care trust fund under IC 12-15-15-1.1(d) for payments under IC 12-15-15-1.1(b) for the state fiscal year beginning July 1, 1998, and ending June 30, 1999, shall be used to fund the state's share of disproportionate share payments to providers under IC 12-15-19-2.1. The remainder of the intergovernmental transfers under IC 12-15-15-1.1(d) for the state fiscal year shall be transferred to the state uninsured parents program fund established under IC 12-17.8-2-1 to fund the state's share of funding for the uninsured parents program established under IC 12-17.7.

(D) If the office of the uninsured parents program

established under IC 12-17.7-2-1 does not implement an uninsured parents program before July 1, 2003, the intergovernmental transfers transferred to the state uninsured parents program fund under clause (B) shall be returned to the Medicaid indigent care trust fund to be used to fund the state's share of Medicaid add-on payments to hospitals licensed under IC 16-21 pursuant to a payment methodolgy developed by the office.

SECTION 26. IC 12-15-41 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 41. Annual Review of Medicaid Nursing Facility Residents

Sec. 1. "Minimum data set" or "MDS" means a core set of screening and assessment elements, including common definitions and coding categories, used as:

(1) a comprehensive assessment for all residents of long term care facilities certified to participate in the Medicaid program; and

(2) a standardized communication about resident problems, strengths, and conditions within the facilities, between facilities, and between facilities and outside agencies.

Sec. 2. A nursing facility certified to provide nursing facility care to Medicaid recipients shall submit to the office annually minimum data set (MDS) information for each of its Medicaid residents.

Sec. 3. (a) The office or the office's designated contractor shall evaluate the MDS information submitted for each Medicaid resident. The evaluation must consist of an assessment of the following:

(1) The individual's medical needs.

(2) The availability of services, other than services provided in a nursing facility, that are appropriate to the individual's needs.

(3) The cost effectiveness of providing services appropriate to the individual's needs that are provided outside of, rather than within, a nursing facility.

(b) The assessment must be conducted in accordance with rules adopted under IC 4-22-2 by the office.

Sec. 4. If the office determines under section 3 that an individual's needs could be met in a setting other than a nursing facility and in a cost effective manner, the office shall counsel the

individual and provide the individual with written notice containing the following:

(1) The reasons for the office's determination.

(2) A detailed description of services available to the individual that, if used by the individual, make the continued placement of the individual in a nursing facility inappropriate.

SECTION 27. IC 12-16-14.1 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]:

Chapter 14.1. Transfer of Funds to Uninsured Parents Program

Sec. 1. (a) All funds in a county hospital care for the indigent fund on June 30, 2002, derived from taxes levied under IC 12-16-14-1(1) (before its repeal) or allocated under IC 12-16-14-1(2) (before its repeal) before January 1, 2002, shall be immediately transferred to the state hospital care for the indigent fund.

(b) All funds in a county hospital care for the indigent fund on June 30, 2002, derived from taxes levied under IC 12-16-14-1(1) (before its repeal) or allocated under IC 12-16-14-1(2) (before its repeal) on or after January 1, 2002, through June 30, 2002, shall be immediately transferred to the state uninsured parents program fund established under IC 12-17.8-2-1.

(c) Subject to subsection (e), beginning July 1, 2002, all tax receipts derived from taxes levied under IC 12-16-14-1(1) (before its repeal) or allocated under IC 12-16-14-1(2) (before its repeal) before January 1, 2002, shall be paid into the county general fund. Before the fifth day of each month, all of the tax receipts paid into the general fund under this subdivision during the preceding month shall be transferred to the state hospital care for the indigent fund.

(d) Beginning July 1, 2002, all tax receipts derived from taxes levied under IC 12-16-14-1(1) (before its repeal) or allocated under IC 12-16-14-1(2) (before its repeal) on or after January 1, 2002, through June 30, 2002, shall be paid into the county general fund. Before the fifth day of each month, all of the tax receipts paid into the general fund under this subdivision during the preceding month shall be transferred to the state uninsured parents program fund established by IC 12-17.8-2-1.

(e) If the state hospital care for the indigent fund is closed under section 2(e) of this chapter at the time a transfer of receipts is to be made to the fund, the receipts shall be transferred to the state

uninsured parents program fund established by IC 12-17.8-2-1.

Sec. 2. (a) Beginning July 1, 2002, the division shall transfer to the state uninsured parents program fund established by IC 12-17.8-2-1 all funds deposited in the state hospital care for the indigent fund derived from taxes levied under IC 12-16-14-1(1) (before its repeal) or allocated under IC 12-16-14-1(2) (before its repeal) for the period beginning January 1, 2002, through June 30, 2002. Before the fifth day of each month, all such funds deposited during the preceding month shall be transferred to the state uninsured parents program fund established by IC 12-17.8-2-1.

(b) Subject to subsections (c), (d), and (f), beginning July 1, 2002, all funds deposited in the state hospital care for the indigent fund derived from taxes levied under IC 12-16-14-1(1) (before its repeal) or allocated under IC 12-16-14-1(2) (before its repeal) before January 1, 2002, shall be used by the division to pay claims for services:

(1) eligible for payment under the hospital care for the indigent program (before its repeal); and

(2) provided before July 1, 2002.

(c) This section does not delay, limit, or reduce either of the following:

(1) The appropriation from the state hospital care for the indigent fund for Medicaid current obligations for the state fiscal year beginning July 1, 2000, and ending June 30, 2001 under P.L.273-1999, SECTION 8, for purposes of IC 12-15-15-9(a) through IC 12-15-15-9(d) for the state fiscal year beginning July 1, 2000, and ending June 30, 2001.

(2) The transfer of additional funds from the state hospital care for the indigent fund for Medicaid current obligations anticipated under IC 12-15-15-9(b) for purposes of IC 12-15-15-9(a) through IC 12-15-15-9(d) for the state fiscal year beginning July 1, 2000, and ending June 30, 2001.

(d) The division shall cooperate with the office of Medicaid policy and planning established under IC 12-15-1-1 in causing the appropriations and transfers from the state hospital care for the indigent fund described in subsection (c) to occur. The office of Medicaid policy and planning shall use these appropriations and transfers for purposes of IC 12-15-15-9(a) through IC 12-15-15-9(d) for the state fiscal year beginning July 1, 2000, and ending June 30, 2001.

(e) The state hospital care for the indigent fund shall close upon the earlier of the following:

(1) The payment of all funds in the fund.

(2) The payment of all claims for services provided before July 1, 2002, that were eligible for payment under the hospital care for the indigent program under IC 12-16 (before its repeal).

(f) Notwithstanding subsection (e), if at any time before the closing of the state hospital care for the indigent fund the amount of funds on deposit exceeds the amount necessary to pay the claims for services provided before July 1, 2002, that were eligible for payment under the hospital care for the indigent program under IC 12-16 (before its repeal), those excess funds shall be transferred from the fund to the Medicaid program for use as the state's share of funding for payments to hospitals under IC 12-15-15-9(a) and IC 12-15-15-9(e).

(g) Upon the closing of the state hospital care for the indigent fund, no further obligation shall be owed under the hospital care for the indigent program under IC 12-16 (before its repeal).

Sec. 3. If the office of the uninsured parents program established by IC 12-17.7-2-1 does not implement an uninsured parents program before July 1, 2003, the amounts transferred under this chapter to the state uninsured parents program fund established by IC 12-17.8-2-1 shall be returned to the state hospital care for the indigent fund.

SECTION 28. IC 12-16.1 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]:

ARTICLE 16.1. HOSPITAL CARE FOR THE INDIGENT

Chapter 1. Applicability

Sec. 1. This article applies only if the office of the uninsured parents program established by IC 12-17.7-2-1 does not implement an uninsured parents program before July 1, 2003.

Chapter 2. Administration and General Provisions

Sec. 1. The division shall administer the hospital care for the indigent program under this article.

Sec. 2. The division shall adopt necessary forms to be used by the patients, hospitals, physicians, and county offices in carrying out the hospital care for the indigent program.

Sec. 3. The following persons have the same rights and obligations with respect to the hospital care for the indigent program as the persons have with respect to the Medicaid program under IC 12-15-8 and IC 12-15-29:

(1) The division.

(2) Applicants and recipients of assistance.

(3) Insurers.

(4) Persons against whom applicants and recipients of assistance have claims.

(5) The office of Medicaid policy and planning.

Sec. 4. To the extent permitted under federal statutes or regulations, patient days for patients under the hospital care for the indigent program shall be included in calculating allowable disproportionate share additional payments under 42 U.S.C. 1395ww(d).

Sec. 5. The hospital care for the indigent program does not apply to inmates and patients of institutions of the department of correction, the state department of health, the division of mental health, or the division of disability, aging, and rehabilitative services.

Chapter 3. Eligibility for Assistance

Sec. 1. (a) An Indiana resident who meets the income and resource standards established by the division under section 3 of this chapter is eligible for assistance to pay for any part of the cost of care provided in a hospital in Indiana that was necessitated after the onset of a medical condition that was manifested by symptoms of sufficient severity that the absence of immediate medical attention would probably result in any of the following:

(1) Placing the individual's life in jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of a bodily organ or part.

(b) A qualified resident is also eligible for assistance to pay for the part of the cost of care that is a direct consequence of the medical condition that necessitated the emergency care.

Sec. 2. (a) An individual who is not an Indiana resident is eligible for assistance to pay for the part of the cost of care provided in a hospital in Indiana that was necessitated after the onset of a medical condition that was manifested by symptoms of sufficient severity that the absence of immediate medical attention would probably result in any of the following:

(1) Placing the individual's life in jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(b) An individual is eligible for assistance under subsection (a) only if the following qualifications exist:

(1) The individual meets the income and resource standards established by the division under section 3 of this chapter.

(2) The onset of the medical condition that necessitated medical attention occurred in Indiana.

Sec. 3. (a) The division shall adopt rules under IC 4-22-2 to establish income and resource eligibility standards for patients whose care is to be paid for under the hospital care for the indigent program.

(b) To the extent possible, rules adopted under this section must meet the following conditions:

(1) Be consistent with IC 12-15-21-2 and IC 12-15-21-3.

(2) Be adjusted at least one (1) time every two (2) years.

(c) The income and eligibility standards established under this section do not include any spend down provisions available under IC 12-15-21.

(d) In addition to the conditions imposed under subsection (b), rules adopted under this section must exclude a Holocaust victim's settlement payment received by an eligible individual from the income and eligibility standards for patients whose care is to be paid for under the hospital care for the indigent program.

Sec. 4. A hospital shall provide a patient and, if the patient is not able to understand the statement, the patient's representative with a statement of the eligibility and benefit standards adopted by the division if at least one (1) of the following occurs:

(1) The hospital has reason to believe that the patient may be indigent.

(2) The patient requests a statement of the standards.

Chapter 4. Application for Assistance

Sec. 1. To receive payment from the division for the costs incurred in providing care to an indigent person, a hospital must file an application with the county office of the county in which the hospital is located.

Sec. 2. A hospital must file the application with a county office not more than thirty (30) days after the patient has been admitted to the hospital, unless the patient is medically unable to sign the application and the next of kin or legal representative of the patient is unavailable.

Sec. 3. The division shall adopt rules under IC 4-22-2 prescribing the following:

(1) The form of an application.

(2) The establishment of procedures for applications.

(3) The time for submitting and processing claims.

Sec. 4. The division and a county office shall make application forms available to a hospital upon request.

Sec. 5. A hospital or an attending physician may assist the patient in the preparation of an application for assistance under the hospital care for the indigent program.

Sec. 6. A person who in good faith provides assistance in the completion of an application under this chapter is immune from civil or criminal liability arising from the assistance.

Sec. 7. (a) A patient must sign an application if the patient is medically able to sign.

(b) If a patient is medically unable to sign an application, the patient's next of kin or a legal representative of the patient, if available, may sign the application.

(c) If no person under subsections (a) and (b) is able to sign the application to file a timely application, a hospital representative may sign the application instead of the patient.

Sec. 8. (a) A patient may file an application directly with the county office in the county where the hospital providing care is located if the application is filed not more than thirty (30) days after the patient's admission to the hospital.

(b) Reimbursement for the costs incurred in providing care to an eligible person may only be made to the providers of the care.

Chapter 5. Eligibility Determinations; Investigations

Sec. 1. A county office shall, upon receipt of an application of a patient admitted to a hospital, promptly investigate to determine the patient's eligibility under the hospital care for the indigent program.

Sec. 2. (a) The hospital providing medical care to a patient shall provide information the hospital has that would assist in the verification of indigency of a patient.

(b) A hospital that provides information under subsection (a) is immune from civil and criminal liability for divulging the information.

Sec. 3. If the division or county office is unable, after prompt and diligent efforts, to verify information contained in the application that is reasonably necessary to determine eligibility, the division or county office may deny assistance under the hospital care for the indigent program.

Sec. 4. The division or county office shall notify, in writing, the patient and the hospital of the following:

(1) A decision concerning eligibility.

(2) The reasons for a denial of eligibility.

(3) That either party has the right to appeal the decision.

Chapter 6. Denial of Eligibility; Appeals; Judicial Review

Sec. 1. If the division or county office determines that a patient is not eligible for payment of medical or hospital care, an affected person may appeal to the division not later than ninety (90) days after the mailing of notice of that determination to the affected person at the person's last known address.

Sec. 2. If the division or county office:

(1) fails to complete an investigation and determination of eligibility under the hospital care for the indigent program within forty-five (45) days after the receipt of the application filed under IC 12-16.1-4; or

(2) fails or refuses to accept responsibility for payment of medical or hospital care under the hospital care for the indigent program;

a person affected may appeal to the division not more than ninety (90) days after the receipt of the application filed under IC 12-16.1-4.

Sec. 3. The division shall fix a time and place for a hearing before a hearing officer appointed by the director of the division.

Sec. 4. A notice of the hearing shall be served upon all persons interested in the matter at least twenty (20) days before the time fixed for the hearing.

Sec. 5. (a) Following the hearing, the division shall determine the eligibility of the person for payment of the cost of medical or hospital care under the hospital care for the indigent program.

(b) If the person is found eligible, the division shall pay the reasonable cost of the care to the persons furnishing the care, subject to the limitations in IC 12-16.1-7.

Sec. 6. A person aggrieved by a determination under section 5(a) of this chapter may appeal the determination under IC 4-21.5.

Sec. 7. (a) The division shall adopt rules under IC 4-22-2 that provide for an administrative appeal procedure that is responsive to the needs of patients and providers.

(b) The procedure must provide for the following:

(1) The location of hearings.

(2) The presentation of evidence.

(3) The use of telecommunications.

Chapter 7. Cost of Care and Payment

Sec. 1. The division shall pay the following, subject to the limitations in section 4 of this chapter:

(1) The necessary costs of medical or hospital care for indigent patients.

(2) The cost of transportation to the place of treatment arising

out of the medical or hospital care for indigent patients.

Sec. 2. (a) Except as provided in section 5 of this chapter, claims for payment shall be segregated by year using the patient's admission date.

(b) Each year, the division shall pay claims as provided in section 4 of this chapter without regard to the county of admission or that county's transfer to the state fund.

Sec. 3. A payment made to a hospital under the hospital care for the indigent program must be on a warrant drawn on the state hospital care for the indigent fund established under IC 12-16-14.

Sec. 4. (a) Each year, the division shall pay two-thirds (2/3) of each claim upon submission and approval of the claim.

(b) If the amount of money in the state hospital care for the indigent fund in a year is insufficient to pay two-thirds (2/3) of each approved claim for patients admitted in that year, the state's and a county's liability to providers under the hospital care for the indigent program for claims approved for patients admitted in that year is limited to the sum of the following:

(1) The amount transferred to the state hospital care for the indigent fund from county hospital care for the indigent funds in that year under IC 12-16.1-14.

(2) Any contribution to the fund in that year.

(3) Any amount that was appropriated to the state hospital care for the indigent fund for that year by the general assembly.

(4) Any amount that was carried over to the state hospital care for the indigent fund from a preceding year.

(c) This section does not obligate the general assembly to appropriate money to the state hospital care for the indigent fund.

Sec. 5. Before the end of each state fiscal year, the division shall, to the extent there is money in the state hospital care for the indigent fund, pay each provider under the hospital care for the indigent program a pro rata part of the one-third (1/3) balance on each approved claim for patients admitted during the preceding year.

Sec. 6. If:

(1) a claim for a patient admitted during a particular year is not submitted by the deadline established by the division; and

(2) the failure to submit the claim is not the fault of the provider;

the claim shall be considered a claim for the year the claim is submitted for purposes of payment under this chapter.

Sec. 7. The division and a county office are not responsible under the hospital care for the indigent program for the payment of any part of the costs of providing care in a hospital to an individual who is not either of the following:

(1) A citizen of the United States.

(2) A lawfully admitted alien.

Sec. 8. The division and a county office are not liable for any part of the cost of care provided to an individual who has been determined to be a patient described in the rules adopted under IC 12-16.1-10.

Sec. 9. IC 12-16.1-2 through IC 12-16.1-16 do not affect the liability of a county with respect to claims for hospital care for the indigent for patients admitted before January 1, 1987.

Sec. 10. (a) The budget agency shall estimate for each fiscal year the cost savings to the state hospital care for the indigent fund as the result of the provision of Medicaid to an individual described in IC 12-15-2-12 and IC 12-15-2-13.

(b) The budget agency shall, each fiscal year, recommend to the general assembly that an amount equal to the cost savings described in subsection (a) be transferred from the state hospital care for the indigent fund to the state general fund.

Sec. 11. Providers eligible for payment under IC 12-15-15-9 may not receive payment under this chapter.

Sec. 12. All providers receiving payment under this chapter agree to accept, as payment in full, the amount paid for the hospital care for the indigent program for those claims submitted for payment under the program, with the exception of authorized deductibles, co-insurance, co-payment, or similar cost sharing charges.

Chapter 8. Disproportionate Share Providers

Sec. 1. As used in this chapter, "inpatient days" includes:

(1) days provided by an acute care subunit of the provider; and

(2) inpatient days attributable to Medicaid and hospital care for the indigent beneficiaries from other states.

Sec. 2. A payment adjustment consisting of an additional percentage payment for each service paid under the hospital care for the indigent program made to a disproportionate share hospital licensed under IC 16-21 that meets the requirements under section 3 of this chapter.

Sec. 3. A provider is a disproportionate share hospital if the provider's Medicaid inpatient utilization rate is at least one (1)

standard deviation above the mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana.

Sec. 4. A provider's Medicaid inpatient utilization rate is a fraction (expressed as a percentage) in which:

(1) the numerator is the provider's total number of Medicaid and health care for the indigent inpatient days in a cost reporting period; and

(2) the denominator is the total number of the provider's inpatient days in that same period.

Sec. 5. A disproportionate share hospital must receive a twenty percent (20%) adjustment for each service.

Chapter 9. Rate of Payment

Sec. 1. The rate of payment for the services and materials provided by hospitals and physicians under the hospital care for the indigent program is the same rate as payment for the same type of services and materials under the rules adopted by the secretary under Medicaid.

Chapter 10. Rules

Sec. 1. The division shall, with the advice of the division's medical staff, the division of mental health, the division of disability, aging, and rehabilitative services, and other individuals selected by the director of the division, adopt rules under IC 4-22-2 to do the following:

(1) Provide for review and approval of services paid under the hospital care for the indigent program.

(2) Establish limitations consistent with medical necessity on the duration of services to be provided.

(3) Specify the amount of and method for reimbursement for services.

(4) Specify the conditions under which payments will be denied and improper payments will be recovered.

Sec. 2. To the extent possible, rules adopted under section 1 of this chapter must be consistent with IC 12-15-21-2 and IC 12-15-21-3.

Sec. 3. The rules adopted under section 1 of this chapter must include rules that will deny payment for services provided to a patient after the patient is medically stable and can safely be discharged.

Sec. 4. (a) The division shall adopt rules under IC 4-22-2 necessary to establish a statewide collection system of data concerning the hospital care for the indigent program.

(b) The following data must be collected:

(1) Patient demographics.

(2) Types of services provided by hospitals.

(3) Costs of particular types of services provided by hospitals.

(c) A hospital that provides services under the hospital care for the indigent program shall file copies of all claims submitted under the program with the contractor engaged by the division to adjudicate claims.

Sec. 5. The division may adopt rules under IC 4-22-2 that are in addition to and consistent with the rules required to be adopted under IC 12-16.1-6 governing appeals brought under the hospital care for the indigent program to the division.

Chapter 11. Recovery of Payments by Division

Sec. 1. The division may recover amounts paid under the hospital care for the indigent program by the division from the following:

(1) A patient approved for assistance.

(2) A person legally responsible for those patients approved for assistance.

(3) The estate of the patient or person.

Sec. 2. The division is subrogated, to the extent of the assistance given by the division, to the rights that a patient receiving assistance under the hospital care for the indigent program has against any other person who is in any part liable for the illness or injury for which assistance was granted.

Chapter 12. County With Health and Hospital Corporation; Responsibility for Medical Cost

Sec. 1. This chapter applies to a county having a health and hospital corporation created under IC 16-22-8-6.

Sec. 2. The division is responsible for the emergency medical care given in a hospital to an individual who qualifies for assistance under this chapter, subject to the limitations in IC 12-16.1-7.

Sec. 3. The hospital providing care shall transfer the patient to a hospital operated by the health and hospital corporation as soon as the attending physician determines that the patient's medical condition permits the transfer without risk of injury to the patient.

Sec. 4. (a) If a hospital owned by the health and hospital corporation is:

(1) unable to care for a patient; or

(2) unable to treat a patient at the time a transfer is requested by the hospital initiating treatment;

the hospital initiating treatment may continue to treat the patient until the patient's discharge.

(b) Subject to the limitations in IC 12-16.1-7, the division shall pay the costs of care.

Sec. 5. The division is not responsible for the following:

(1) The payment of nonemergency medical costs, except as provided under the hospital care for the indigent program.

(2) The payment of medical costs accrued at a hospital owned or operated by a health and hospital corporation, except for hospital care provided under this chapter to a person not residing in Marion County.

Chapter 13. Immunity

Sec. 1. A hospital, a physician, or an agent or employee of a hospital or physician that provides services in good faith under the hospital care for the indigent program is immune from liability to the extent the liability is attributable to at least one (1) of the following:

(1) The requirement that a patient be transferred under IC 12-16.1-12.

(2) The denial of payment under IC 12-16.1-10.

Sec. 2. Section 1(1) of this chapter does not limit liability for the determination that the patient's medical condition permits a transfer under IC 12-16.1-12.

Chapter 14. Property Tax Levy and Funds

Sec. 1. A county hospital care for the indigent fund is established in each county. The fund consists of the following:

(1) A tax levy on the property located in each county.

(2) The financial institutions tax (IC 6-5.5), motor vehicle excise taxes (IC 6-6-5), and commercial vehicle excise taxes (IC 6-6-5.5) that are allocated to the fund.

Sec. 2. (a) The tax required by section 1(1) of this chapter shall be imposed annually by the county fiscal body on all of the taxable property of the county.

(b) The tax shall be collected as other state and county ad valorem property taxes are collected.

Sec. 3. Each county shall impose a hospital care for the indigent tax levy equal to the product of:

(1) the most recent hospital care for the indigent property tax levied by the county; multiplied by

(2) the statewide average assessed value growth quotient, using all the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for the year in which the tax levy under this section will be first due and payable.

Sec. 4. The state board of tax commissioners shall review each

county's property tax levy under this chapter and shall enforce the requirements of this chapter with respect to that levy.

Sec. 5. All receipts derived from the tax levy shall be paid into the county general fund and constitute the county hospital care for the indigent fund.

Sec. 6. (a) The state hospital care for the indigent fund is established.

(b) Before the fifth day of each month, all money contained in a county hospital care for the indigent fund at the end of the preceding month shall be transferred to the state hospital care for the indigent fund.

Sec. 7. (a) The state hospital care for the indigent fund consists of the following:

(1) Money transferred to the state hospital care for the indigent fund from the county hospital care for the indigent funds.

(2) Any contributions to the fund from individuals, corporations, foundations, or others for the purpose of providing hospital care for the indigent.

(3) Money advanced to the fund under IC 12-16.1-15.

(4) Appropriations made specifically to the fund by the general assembly.

(b) This section does not obligate the general assembly to appropriate money to the state hospital care for the indigent fund.

Sec. 8. The division shall administer the state hospital care for the indigent fund and shall use the money currently in the fund to defray the expenses and obligations incurred by the division for hospital care for the indigent. The money in the fund is hereby appropriated.

Sec. 9. Money in the state hospital care for the indigent fund at the end of a state fiscal year remains in the fund and does not revert to the state general fund.

Chapter 15. Advancements From State Fund

Sec. 1. The division may request an advancement of money from the state general fund in anticipation of county property tax revenue being transferred to the state hospital care for the indigent fund.

Sec. 2. (a) The budget director shall determine an interest rate that is at least the interest rate earned by the state on investments made from money in the state general fund.

(b) The interest rate shall be paid on the amount that is advanced from the state general fund.

Sec. 3. The amount that may be advanced, plus the projected interest on that amount, may not exceed the amount of county property tax revenue that is expected to be transferred to the state hospital care for the indigent fund during the six (6) months following the date of the request.

Sec. 4. A request for an advancement must be submitted to the budget agency.

Sec. 5. The state board of finance may, on the recommendation of the director of the budget agency, approve an advancement.

Sec. 6. If an advancement is approved, the county property tax revenue transferred to the state hospital care for the indigent fund shall be immediately used to repay the amount of the interest and advancements made under this section.

Chapter 16. Review of Medical Criteria

Sec. 1. The division shall review changes made after 1985 in the medical criteria used to establish whether a patient is eligible for assistance under IC 12-16.1-3.

Sec. 2. The division's review under this chapter must include the application of the criteria to specific cases and address whether changes to or clarification of the criteria is necessary so that, in practice, the criteria are consistent with the hospital care for the indigent program.

Sec. 3. The division shall provide to an interested party a report of the division's review, including the division's findings, conclusions, and recommendations.

SECTION 29. IC 12-17.7 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2002]:

ARTICLE 17.7. UNINSURED PARENTS PROGRAM

Chapter 1. Definitions

Sec. 1. The definitions in this chapter apply throughout this article.

Sec. 2. (a) "Caretaker relative" means a blood relative and those of half blood.

(b) The term includes an adoptive parent, grandparent, sibling, and a relative of an adoptive parent.

(c) The term also includes a spouse of an individual described in subsection (b), even after the marriage is terminated by death or dissolution.

Sec. 3. "Crowd out" means the extent to which:

(1) an individual substitutes coverage offered under the program for employer sponsored health insurance coverage;

or

(2) employers:

(A) reduce or eliminate health insurance benefits under an employer based health insurance plan; or

(B) increase the employee's share of the cost of benefits under an employer based health insurance plan relative to the total cost of the plan;

as a result of the program.

Sec. 4. "Office" refers to the office of the uninsured parents program established by IC 12-17.7-2-1.

Sec. 5. "Program" refers to the uninsured parents program established under IC 12-17.7-2-2.

Chapter 2. Program Administration

Sec. 1. The office of the uninsured parents program is established within the office of the secretary.

Sec. 2. The office shall design and administer a system to provide health benefits coverage for individuals eligible for the program.

Sec. 3. To the greatest extent possible, the office shall use the same:

(1) eligibility determination;

(2) enrollment;

(3) provider networks; and

(4) claims payment systems;

as are used by the Medicaid managed care program for adults.

Sec. 4. Reviews of the program by the office must:

(1) be conducted in compliance with federal requirements; and

(2) include an analysis of the extent to which crowd out is occurring.

Sec. 5. The office shall do the following:

(1) Establish performance criteria and evaluation measures.

(2) Monitor program performance.

(3) Adopt a formula for establishing the number of eligible individuals to be enrolled in the program, taking into consideration the following:

(A) The cost of establishing and maintaining the program.

(B) The number of eligible individuals.

(C) The fact that the program is not an entitlement program.

(4) Adopt a methodology for enrolling eligible individuals, taking into consideration the fact that the program is not an

entitlement program.

Sec. 6. The office may, in administering the program, contract with community entities, including private entities, for the following:

(1) Outreach for and enrollment in the program.

(2) Provision of services.

(3) Consumer education and public health education.

Sec. 7. (a) The office shall adopt rules under IC 4-22-2 to implement the program.

(b) The office may adopt emergency rules under IC 4-22-2-37.1 to implement the program on an emergency basis.

Sec. 8. Not later than April 1 of each year, the office shall provide a report describing the program's activities during the preceding calendar year to the following:

(1) Budget committee.

(2) Legislative council.

(3) Select joint committee on Medicaid oversight.

Chapter 3. Eligibility, Outreach, and Enrollment

Sec. 1. (a) To be eligible to enroll in the program, an individual must meet the following requirements:

(1) The individual is:

(A) at least nineteen (19); and

(B) less than sixty-five (65);

years of age.

(2) The individual is a caretaker relative of at least one (1) child in a family with an annual income of:

(A) at least twenty-six percent (26%); and

(B) not more than one hundred percent (100%);

of the federal income poverty level.

(3) The child described in subdivision (2) is enrolled in the Medicaid managed care program for children or another Medicaid program that is otherwise appropriate for the child's age and medical condition.

(4) The individual resides on a full-time basis with the family described in subdivision (2).

(5) The individual is a resident of Indiana.

(b) The office may adopt rules under IC 4-22-2 to adjust eligibility requirements based on available program resources.

Sec. 2. (a) Subject to subsection (b), an individual who is eligible for the program shall receive services from the program until the earlier of the following:

(1) The end of a period of twelve (12) consecutive months

following the determination of the individual's eligibility for the program.

(2) The individual becomes eligible for enrollment, or would be eligible for enrollment if the individual were not enrolled in the uninsured parents program, in any other:

(A) Medicaid program; or

(B) health care program administered by local, state, or federal government.

(3) The individual no longer resides on a full-time basis with the family whose income served as the basis for the individual's eligibility for the program.

(4) The individual becomes sixty-five (65) years of age.

(b) Subsection (a) applies only if the individual complies with the program's enrollment requirements.

Sec. 3. The office shall implement outreach strategies that build on community resources.

Sec. 4. An individual may apply at an enrollment center as provided in IC 12-15-4-1 to receive health care services from the program if the individual meets the eligibility requirements of section 1 of this chapter.

Chapter 4. Benefits, Crowd Out, and Cost Sharing

Sec. 1. The benefit package provided under the program must focus on age appropriate preventive, primary, and acute care services.

Sec. 2. The office shall offer health insurance coverage for the following basic services:

(1) Inpatient and outpatient hospital services.

(2) Physicians' services provided by a physician (as defined in 42 U.S.C. 1395x(r)).

(3) Laboratory and x-ray services.

(4) Emergency medical services.

Sec. 3. The office may offer services in addition to those described in section 2 of this chapter if funds for the program exist to pay for the additional services.

Sec. 4. (a) The office shall offer health insurance coverage for the following additional services if the coverage for the services has an actuarial value equal to or greater than the actuarial value of the services provided by the benchmark program determined by the children's health policy board established by IC 4-23-27-2:

(1) Prescription drugs.

(2) Mental health services.

(3) Vision services.

(4) Hearing services.

(5) Dental services.

(b) The office may not impose treatment limitations or financial requirements on the coverage of services for a mental illness if similar treatment limitations or financial requirements are not imposed on coverage for services for other illnesses.

Sec. 5. The office may not impose premiums, deductibles, coinsurance, or other cost sharing upon enrollees in the program.

Sec. 6. The office may do the following:

(1) Determine waiting periods that may not exceed three (3) months and exceptions to the requirement of waiting periods for potential enrollees in the program.

(2) Adopt additional methods for complying with any federal requirements relating to crowd out.

Chapter 5. Provider Contracts

Sec. 1. A provider agreement must include information that the office finds necessary to facilitate carrying out this article.

Sec. 2. A provider who participates in the program must comply with the enrollment requirements established under IC 12-15.

Sec. 3. A provider who participates in the Medicaid program is considered a provider for both the Medicaid program and the program under this article.

Sec. 4. A provider:

(1) who participates in the Medicaid managed care program for children; and

(2) whose practice is not limited to the care and treatment of children only;

is considered a provider for both the Medicaid program and the program under this article.

Sec. 5. If an enrollee in the Medicaid managed care program for children has direct access to a provider:

(1) who has entered into a provider agreement under IC 12-15-11; and

(2) whose practice is not limited to the care and treatment of children only;

an enrollee in the uninsured parents program shall have direct access to the same provider.

Chapter 6. Appeals and Hearings

Sec. 1. An applicant for or a recipient of services under the program may appeal to the office if any of the following occurs:

(1) An application or a request is not acted upon by the office within a reasonable time after the application or request is

filed.

(2) The application is denied.

(3) The applicant or recipient is dissatisfied with the action of the office.

Sec. 2. The secretary shall conduct hearings and appeals concerning the program under IC 4-21.5.

Sec. 3. The office shall, upon receipt of notice of an appeal under section 1 of this chapter, set the matter for hearing and give the applicant or recipient an opportunity for a fair hearing in the county in which the applicant or recipient resides.

Sec. 4. (a) At a hearing held under section 3 of this chapter, the applicant or recipient and the office may introduce additional evidence.

(b) A hearing held under section 3 of this chapter shall be conducted under rules adopted by the secretary for applicants and recipients of Medicaid that are not inconsistent with IC 4-21.5 and the program.

Sec. 5. The office:

(1) may make necessary additional investigations; and

(2) shall make decisions concerning the:

(A) granting of program services; and

(B) amount of program services to be granted;

to an applicant or a recipient that the office believes are justified and in conformity with the program.

Chapter 7. Confidentiality and Release of Information

Sec. 1. The following concerning a program applicant or recipient under the program are confidential, except as otherwise provided in this chapter:

(1) An application.

(2) An investigation report.

(3) An information.

(4) A record.

Sec. 2. The use and the disclosure of the information described in this chapter to persons authorized by law in connection with the official duties relating to:

(1) financial audits;

(2) legislative investigations; or

(3) other purposes directly connected with the administration of the program;

is authorized.

Sec. 3. (a) The release and use of information of a general nature shall be provided as needed for adequate interpretation or

development of the program.

(b) The information described in subsection (a) includes the following:

(1) Total program expenditures.

(2) The number of recipients.

(3) Statistical and social data used in connection with studies.

(4) Reports or surveys on health and welfare problems.

Sec. 4. The office shall make available the following to providers for immediate access to information indicating whether an individual is eligible for the program:

(1) A twenty-four (24) hour telephone system.

(2) A computerized data retrieval system.

Sec. 5. Information released under section 4 of this chapter is limited to the following:

(1) Disclosure of whether an individual is eligible for the program.

(2) The date the individual became eligible for the program and the individual's program number.

(3) Restrictions, if any, on the scope of services to be reimbursed under the program for the individual.

Sec. 6. Information obtained by a provider under this chapter concerning an individual's eligibility for the program is confidential and may only be disclosed to the following:

(1) Another provider involved or potentially involved in the care of the individual.

(2) A person who:

(A) works under the authority of a provider described in subdivision (1); and

(B) requires the information for the provider's legitimate business or clinical purposes.

Sec. 7. If it is established that a provision of this chapter causes the program to be ineligible for federal financial participation, the provision is limited or restricted to the extent that is essential to make the program eligible for federal financial participation.

SECTION 30. IC 12-17.8 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

ARTICLE 17.8. FUNDING OF UNINSURED PARENTS PROGRAM

Chapter 1. County Uninsured Parents Program Funds

Sec. 1. This chapter applies beginning July 1, 2002.

Sec. 2. (a) A county uninsured parents program fund is

established in each county. The fund consists of the following:

(1) A tax levy on the property located in each county.

(2) The financial institutions tax (IC 6-5.5), motor vehicle excise taxes (IC 6-6-5), and commercial vehicle excise taxes (IC 6-6-5.5) that are allocated to the fund.

(b) A county's uninsured parents program fund replaces the county's hospital care for the indigent fund under IC 12-16-14-1 (before its repeal).

(c) The methodology for allocating taxes under subsection (a)(2) to a county uninsured parents program fund shall be the same as the methodology used for allocating taxes to the county's hospital care for the indigent fund under IC 12-16-14-1 (before its repeal).

Sec. 3. (a) The tax required by section 2(a)(1) of this chapter shall be imposed annually by the county fiscal body on all the taxable property of the county.

(b) The tax shall be collected as other state and county ad valorem property taxes are collected.

(c) The initial levy under section 2(a)(1) of this chapter shall occur on the same date following July 1, 2002, that the levy under IC 12-16-14-1(1) (before its repeal) would have next occurred.

Sec. 4. Except as provided in sections 5 and 6 of this chapter, each county shall impose an uninsured parents program property tax levy equal to the product of:

(1) for the initial levy imposed under this chapter after July 1, 2002:

(A) a levy equal ninety percent (90%) of to the hospital care for the indigent property tax levy imposed in calendar year 2001 for taxes first due and payable in calendar year 2002; multiplied by

(B) the statewide average assessed value growth quotient, using all the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for the year in which the tax levy under this subdivision will be first due and payable;

(2) for the second annual levy imposed under this chapter:

(A) a levy equal ninety percent (90%) of to the hospital care for the indigent property tax levy imposed in calendar year 2002 for taxes first due and payable in calendar year 2003; multiplied by

(B) the statewide average assessed value growth quotient, using all the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for the year in which the

tax levy under this subdivision will be first due and payable; and

(3) for all subsequent annual levies imposed under this chapter:

(A) a levy equal to the uninsured parents program property tax levy imposed for taxes first due and payable in the preceding year; multiplied by

(B) the statewide average assessed value growth quotient, using all the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for the year in which the tax levy under this subdivision will be first due and payable.

Sec. 5. A county having a population of at least four hundred thousand (400,000) but less than seven hundred thousand (700,000) shall impose an uninsured parents program property tax levy equal to the product of:

(1) for the initial levy imposed under this chapter following July 1, 2002, a levy equal to:

(A) the difference between:

(i) the hospital care for the indigent property tax levy imposed in calendar year 2001 for taxes first due and payable in calendar year 2002; minus

(ii) four million dollars ($4,000,000); multiplied by

(B) the statewide average assessed value growth quotient, using all the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for the year in which the tax levy under this subdivision will be first due and payable;

(2) for the second annual levy imposed under this chapter, a levy equal to:

(A) the difference between:

(i) the hospital care for the indigent property tax levy imposed in calendar year 2002 for taxes first due and payable in calendar year 2003; minus

(ii) four million dollars ($4,000,000); multiplied by

(B) the statewide average assessed value growth quotient, using all the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for the year in which the tax levy under this subdivision will be first due and payable; and

(3) for all subsequent impositions of the levy, the amount that results from the calculation under section 4(3) of this chapter.

Sec. 6. A county having a population of at least two hundred thousand (200,000) but less than three hundred thousand (300,000) shall impose an uninsured parents program property tax levy equal to the product of:

(1) for the initial levy imposed under this chapter following July 1, 2002, a levy equal to:

(A) the difference between:

(i) the hospital care for the indigent property tax levy imposed in calendar year 2001 for taxes first due and payable in calendar year 2002; minus

(ii) one million dollars ($1,000,000); multiplied by

(B) the statewide average assessed value growth quotient, using all the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for the year in which the tax levy under this subdivision will be first due and payable;

(2) for the second annual levy imposed under this chapter, a levy equal to:

(A) the difference between:

(i) the hospital care for the indigent property tax levy imposed in calendar year 2002 for taxes first due and payable in calendar year 2003; minus

(ii) one million dollars ($1,000,000); multiplied by

(B) the statewide average assessed value growth quotient, using all the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for the year in which the tax levy under this subdivision will be first due and payable; and

(3) for all subsequent impositions of the levy, the amount that results from the calculation under section 4(3) of this chapter.

Sec. 7. The state board of tax commissioners shall review each county's property tax levy under this chapter and shall enforce the requirements of this chapter with respect to that levy.

Sec. 8. All receipts derived from the tax levy shall be paid into the county general fund and constitute the county uninsured parents program fund.

Chapter 2. State Uninsured Parents Program Fund

Sec. 1. (a) The state uninsured parents program fund is established.

(b) Before the fifth day of each month, all money contained in a county uninsured parents program fund at the end of the preceding month shall be transferred to the state uninsured

parents program fund.

Sec. 2. (a) The state uninsured parents program fund consists of the following:

(1) The money transferred to the state uninsured parents program fund from the county uninsured parents program funds.

(2) The money transferred to the state uninsured parents program fund under IC 12-15-20-2(5).

(3) The money transferred to the state uninsured parents program fund under IC 12-16-14.1.

(4) Any contributions to the fund from individuals, corporations, foundations, public or private trust funds, or others for the purpose of providing medical assistance to uninsured parents.

(5) The money advanced to the fund under section 5 of this chapter.

(6) The appropriations made specifically to the fund by the general assembly or a state board, trust, or fund.

(7) Any intergovernmental transfer from any source.

(b) This section does not obligate the general assembly or any state board, trust, or fund to appropriate money to the state uninsured parents program fund.

Sec. 3. The office of the uninsured parents program established by IC 12-17.7-2-1 shall administer the state uninsured parents program fund and shall use the money in the fund to defray the expenses and obligations incurred by the office for providing medical services covered by the program. The money in the fund is hereby appropriated.

Sec. 4. (a) Money in the state uninsured parents program fund at the end of a state fiscal year remains in the fund and does not revert to the state general fund.

(b) For each state fiscal year beginning July 1, 2002, the office of the uninsured parents program established by IC 12-17.7-2-1 shall transfer from the state uninsured parents program fund an amount equal to the amount determined by multiplying thirty-five million dollars ($35,000,000) by the federal medical assistance percentage for the state fiscal year. The transferred amount shall be used for Medicaid current obligations. The transfer may be made in a single payment or multiple payments throughout the state fiscal year.

Sec. 5. (a) The office of the uninsured parents program established by IC 12-17.7-2-1 may request an advancement of

money from the state general fund in anticipation of county property tax revenue being transferred to the state uninsured parents program.

(b) The director of the budget agency shall determine an interest rate that is at least the interest rate earned by the state on investments made from money in the general fund and the rate so determined by the director of the budget agency shall be paid on the amount that is advanced from the state general fund.

(c) The amount that may be advanced, plus the projected interest on that amount, may not exceed the amount of county property tax revenue that is expected to be transferred to the state uninsured parents program fund during the six (6) months following the date of the request.

(d) A request for an advancement must be submitted to the budget agency.

(e) The state board of finance may, on the recommendation of the director of the budget agency, approve an advancement.

(f) If an advancement is approved, the county property tax revenue transferred to the state uninsured parents program fund shall be immediately used to repay the amount of the interest and advancements made under this section.

Sec. 6. The treasurer of state shall invest the money in the state uninsured parents program fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested.

SECTION 31. IC 34-30-2-45.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: **Sec. 45.5. IC 12-16.1-4-6 (Concerning persons who aid a patient in completing an application for assistance under the hospital care for the indigent program).**

SECTION 32. IC 34-30-2-45.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: **Sec. 45.7. IC 12-16.1-5-2 (Concerning hospitals for providing information verifying indigency of patient).**

SECTION 33. IC 34-30-2-45.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: **Sec. 45.9. IC 12-16.1-13-1 (Concerning hospitals or persons providing services under the hospital care for the indigent program).**

SECTION 34. IC 35-43-5-7.3 IS AS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2002]: **Sec. 7.3. (a) Except as provided**

in subsection (b), a person who knowingly or intentionally:

(1) files an uninsured parents program claim, including an electronic claim, in violation of IC 12-17.7;

(2) obtains payment from the uninsured parents program under IC 12-17.7 by means of a false or misleading oral or written statement or other fraudulent means;

(3) acquires a provider number under the uninsured parents program except as authorized by law;

(4) alters with intent to defraud or falsifies documents or records of a provider (as defined in 42 CFR 1002.301) that are required to be kept under the uninsured parents program; or

(5) conceals information for the purpose of applying for or receiving unauthorized payments from the uninsured parents program;

commits insurance fraud, a Class D felony.

(b) The offense described in subsection (a) is a Class C felony if the fair market value of the offense is at least one hundred thousand dollars ($100,000).

SECTION 35. IC 12-10-12-27.1; IC 12-10-12-28.5 IC 12-15-19-10.1 IS REPEALED [EFFECTIVE JULY 1, 2001].

SECTION 36. IC 12-17.6-1-2.6 IS REPEALED [EFFECTIVE JANUARY 1, 2002].

SECTION 37. THE FOLLOWING ARE REPEALED [EFFECTIVE JULY 1, 2002]: IC 12-7-2-118; IC 12-16-2; IC 12-16-3; IC 12-16-4; IC 12-16-5; IC 12-16-6; IC 12-16-7; IC 12-16-8; IC 12-16-9; IC 12-16-10; IC 12-16-11; IC 12-16-12; IC 12-16-13; IC 12-16-15; IC 12-16-16; IC 34-30-2-44; IC 34-30-2-45; IC 34-30-2-45.3.

SECTION 38. [EFFECTIVE JULY 1, 2002] **Notwithstanding any other provision of this act, the following are not prohibited or limited:**

(1) A levy of taxes under IC 12-16-14-1(1) before July 1, 2002, or the collection of those taxes after July 1, 2002.

(2) An assessment of taxes under IC 12-16-14-1(2) before July 1, 2002, or the collection and allocation of those taxes after July 1, 2002.

SECTION 39. [EFFECTIVE JULY 1, 2001] **(a) As used in this SECTION, "office" refers to the office of the secretary of family and social services established by IC 12-8-1-1.**

(b) The office shall apply to the federal Health Care Financing Administration for approval of the necessary state plan amendment and demonstration waiver (42 U.S.C. 1396 et seq.) to implement the uninsured parents program established under

IC 12-17.7, as added by this act, as a nonentitlement Medicaid program.

(c) The office may not implement a state plan amendment or a waiver until the office files an affidavit with the governor attesting that both the amendment and waiver applied for under this SECTION are in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that both the amendment and the waiver are approved.

(d) If the office receives approval of the state plan amendment and waiver request from the federal Health Care Financing Administration and the governor receives the affidavit under subsection (c), the office shall implement the state plan amendment and waiver on the earlier of the following dates:

(1) Thirty (30) days after the governor receives the affidavit under subsection (c).

(2) June 30, 2003.

(e) Notwithstanding subsection (d), the office shall not in any event implement the state plan amendment and waiver:

(1) before July 1, 2002; and

(2) before requisite funds for the program's implementation are available or projected to be available, as determined by the office.

(f) As soon as possible after the date that the office implements the state plan amendment and waiver, the office shall:

(1) publish a public notice; and

(2) adopt a rule under IC 4-22-2;

stating the implementation date of the uninsured parents program.

(g) If the office does not file an affidavit under subsection (c):

(1) the office may not implement IC 12-17.7, as added by this act;

(2) any funds in a county uninsured parents program fund shall be returned to the county's hospital care for the indigent fund; and

(3) any funds in the state uninsured parents program fund shall be returned to the state hospital care for the indigent fund.

(h) This SECTION expires July 31, 2003.

SECTION 40. **An emergency is declared for this act.**

COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred House Bill 1727, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 4, between lines 10 and 11, begin a new paragraph and insert:

"SECTION 3. IC 12-7-2-24.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2002]: **Sec. 24.5. "Caretaker relative" for purposes of IC 12-17.7, has the meaning set forth in IC 12-17.7-1-2.**".

Page 4, between lines 16 and 17, begin a new paragraph and insert:

"SECTION 4. IC 12-7-2-69 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 69. (a) "Division", except as provided in subsections (b) and (c), refers to any of the following:

(1) The division of disability, aging, and rehabilitative services established by IC 12-9-1-1.

(2) The division of family and children established by IC 12-13-1-1.

(3) The division of mental health established by IC 12-21-1-1.

(b) The term refers to the following:

(1) For purposes of the following statutes, the division of disability, aging, and rehabilitative services established by IC 12-9-1-1:

(A) IC 12-9.

(B) IC 12-10.

(C) IC 12-11.

(D) IC 12-12.

(2) For purposes of the following statutes, the division of family and children established by IC 12-13-1-1:

(A) IC 12-13.

(B) IC 12-14.

(C) IC 12-15.

(D) IC 12-16.

(E) **IC 12-16.1.**

(F) IC 12-17.

~~(F)~~ **(G)** IC 12-17.2.

~~(G)~~ **(H)** IC 12-17.4.

~~(H)~~ **(I)** IC 12-18.

~~(I)~~ **(J)** IC 12-19.

~~(J)~~ **(K)** IC 12-20.

(3) For purposes of the following statutes, the division of mental health established by IC 12-21-1-1:

(A) IC 12-21.

(B) IC 12-22.

(C) IC 12-23.

(D) IC 12-25.

(c) With respect to a particular state institution, the term refers to the division whose director has administrative control of and responsibility for the state institution.

(d) For purposes of IC 12-24, IC 12-26, and IC 12-27, the term refers to the division whose director has administrative control of and responsibility for the appropriate state institution.

SECTION 5. IC 12-7-2-76, AS AMENDED BY P.L.128-1999, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: Sec. 76. (a) "Eligible individual", for purposes of IC 12-10-10, has the meaning set forth in IC 12-10-10-4.

(b) "Eligible individual" has the meaning set forth in IC 12-14-18-1.5 for purposes of the following:

(1) IC 12-10-6.

(2) IC 12-14-2.

(3) IC 12-14-18.

(4) IC 12-14-19.

(5) IC 12-15-2.

(6) IC 12-15-3.

~~(7) IC 12-16-3.~~

~~(8)~~ **(7)** IC 12-17-1.

~~(9)~~ **(8)** IC 12-20-5.5.".

Page 4, between lines 36 and 37, begin a new paragraph and insert:

"SECTION 7. IC 12-7-2-104.5, AS ADDED BY P.L.128-1999, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: Sec. 104.5. "Holocaust victim's settlement payment" has the meaning set forth in IC 12-14-18-1.7 for purposes of the following:

(1) IC 12-10-6.

(2) IC 12-14-2

(3) IC 12-14-18.

(4) IC 12-14-19.

(5) IC 12-15-2.

(6) IC 12-15-3.

~~(7) IC 12-16-3.~~

~~(8)~~ **(7)** IC 12-17-1.

~~(9)~~ **(8)** IC 12-20-5.5.

SECTION 8. IC 12-7-2-110, AS AMENDED BY P.L.142-2000, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 110. "Hospital" means the following:

(1) For purposes of IC 12-15-11.5, the meaning set forth in IC 12-15-11.5-1.

(2) For purposes of IC 12-15-18, the meaning set forth in IC 12-15-18-2.

(3) For purposes of ~~IC 12-16, except IC 12-16-1,~~ **IC 12-16.1,** the term refers to a hospital licensed under IC 16-21.

SECTION 9. IC 12-7-2-118.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: **Sec. 118.1. "Inpatient days", for purposes of IC 12-16.1-8, has the meaning set forth in IC 12-16.1-8-1.**

SECTION 10. IC 12-7-2-131.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 131.3. "Minimum data set", for purposes of IC 12-15-41, has the meaning set forth in IC 12-15-41-1.**".

Page 5, between lines 41 and 42, begin a new paragraph and insert:

"SECTION 10. IC 12-7-2-164 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 164. "Resident" has the following meaning:

(1) For purposes of IC 12-10-15, the meaning set forth in IC 12-10-15-5.

(2) For purposes of ~~IC 12-16, except IC 12-16-1,~~ **IC 12-16.1,** an individual who has actually resided in Indiana for at least ninety (90) days.

(3) For purposes of IC 12-20-8, the meaning set forth in IC 12-20-8-1.

(4) For purposes of IC 12-24-5, the meaning set forth in IC 12-24-5-1.

SECTION 11. IC 12-10-12-27 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 27. (a) **Except as provided in subsection (b),** the agency shall, subject to the approval of the division, designate at least one (1) individual who may authorize temporary admittance to a nursing facility under

~~(1) subsection (b); and~~

~~(2)~~ sections 28, 30, and 31 of this chapter

without the approval required under this chapter.

(b) An individual designated under subsection (a) may **not** authorize

temporary admittance to a nursing home **under subsection (a)** for a ~~resident~~ **nonresident** of Indiana. ~~if the resident:~~

~~(1) has received treatment from and is being discharged from a hospital that is located in a state other than Indiana; and~~

~~(2) will be participating in preadmission screening under this chapter.~~

~~(c) Notwithstanding a rule adopted under section 12 of this chapter, a screening team appointed to screen a nonresident under this section must:~~

~~(1) conduct its assessment under section 16 of this chapter; and~~

~~(2) report its findings;~~

~~within ten (10) days after its appointment.~~

SECTION 12. IC 12-15-1-16.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 16.5. Each state department or agency and each local governmental unit shall cooperate with the office who shall conduct a study to examine means in which to cover Medicaid eligible care provided by the departments, agencies, or units with state or local funding.**".

Page 6, line 2, delete "JANUARY 1, 2001" and insert "JULY 1, 2000".

Page 6, line 6, delete "for the period beginning January 1, 2001, through June 30,".

Page 6, line 7, delete "2001, and for".

Page 6, line 7, after "1997," delete "2001" and insert "**2000**".

Page 6, line 21, delete "For the period beginning January 1, 2001,".

Page 6, delete line 22.

Page 6, line 23, delete "June 30, 2001, the" and insert "**The**".

Page 6, line 23, delete "calculate" and insert "**identify**".

Page 6, run in lines 21 and 23.

Page 6, line 25, delete "IC 16-22 or" and insert "**IC 16-22-2, IC 16-22-8, and**".

Page 6, line 26, delete "calculated" and insert "**identified**".

Page 6, line 27, delete ", for the period beginning".

Page 6, delete line 28.

Page 6, line 29, delete "year ending after June 30, 2001,".

Page 6, run in lines 27 and 29.

Page 6, line 31, delete "IC 16-22 or" and insert "**IC 16-22-2, IC 16-22-8, and**".

Page 6, line 34, delete "through" and insert "**and ending**".

Page 6, line 40, after "Subtract the" insert "**amount calculated under**".

Page 6, line 40, after "TWO" delete "amount".

Page 6, line 40, after "from the" insert "**amount calculated under**".

Page 6, line 41, delete "amount".

Page 6, between lines 41 and 42, begin a new line block indented and insert:

"**STEP FIVE: From the amount calculated under STEP FOUR, distribute to a hospital established and operated under IC 16-22-8 an amount equal to one hundred percent (100%) of the difference between:**

(A) the aggregate payments for covered services made under this article to the hospital, excluding payments under IC 12-15-16 and IC 12-15-19; and

(B) a reasonable estimate of the amount that would have been paid for the services described in subdivision (1) under Medicare payment principles.

The actual distribution of the amount calculated under this STEP shall be made pursuant to the terms and conditions provided for the hospital in the state plan for medical assistance.

STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.".

Page 6, line 42, delete "FIVE" and insert "**SEVEN**".

Page 7, line 1, delete "FOUR" and insert "**SIX**".

Page 7, line 6, reset in roman "each".

Page 7, line 6, delete "the period".

Page 7, delete line 7.

Page 7, line 8, delete "close of a".

Page 7, line 8, delete "ending after June 30, 2001. Payment for".

Page 7, delete line 9.

Page 7, line 10, delete "be made before December 31, 2001." and insert "**Payment for a state fiscal year ending after June 30, 2001, shall be made before December 31 following the state fiscal year's end.**".

Page 7, line 13, delete "IC 16-22" and insert "**IC 16-22-2**".

Page 7, line 18, delete "the period beginning January 1, 2001, through June 30,".

Page 7, line 19, delete "2001, and after the close of".

Page 7, line 19, delete "ending after June" and insert ".".

Page 7, line 20, delete "30, 2001.".

Page 7, line 24, after "fund" insert "**the state's share of payments under this section and**".

Page 7, line 25, after "IC 12-15-20-2(2)" insert ",".

Page 7, line 25, after "and" insert "**payments for the uninsured parents program under**".

Page 7, line 29, delete "FIVE" and insert "**SEVEN**".

Page 7, between lines 38 and 39, begin a new paragraph and insert:

"**(g) For the state fiscal year beginning July 1, 2000, and ending June 30, 2001, the amount calculated under STEP THREE of subsection (b) shall be adjusted to account for the portion of the state fiscal year prior to the effective date of the federal regulation establishing the Medicaid upper payment limit for non-state government owned or operated hospitals at one hundred fifty percent (150%) of Medicare reimbursement rates.**

(h) For purposes of calculating the amount under STEP THREE of subsection (b), the amount attributable to the period of the state fiscal year described in subsection (g) shall be the maximum payment amount available without exceeding the Medicaid upper payment limit applicable for non-state owned or operated hospitals for that period.".

Replace the effective date in SECTION 8 with "[EFFECTIVE JULY 1, 2001]".

Page 8, line 7, delete "." and insert "**and funds available under IC 12-16-14.1-3.**".

Page 9, between lines 8 and 9, begin a new paragraph and insert:

"SECTION 12. IC 12-15-15-12 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 12. The office may not increase the base amount used to calculate reimbursement rates for inpatient and outpatient hospital services over the base amount used by the office on January 1, 2001.**".

Page 9, between lines 40 and 41, begin a new paragraph and insert:

"SECTION 18. IC 12-15-16-3, AS AMENDED BY P.L.113-2000, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: Sec. 3. (a) For purposes of disproportionate share eligibility, a provider's low income utilization rate is the sum of the following, based on the most recent year for which an audited cost report is on file with the office:

(1) A fraction (expressed as a percentage) for which:

(A) the numerator is the sum of:

(i) the total Medicaid patient revenues paid to the provider; plus

(ii) the amount of the cash subsidies received directly from state and local governments, including payments made under the hospital care for the indigent program (IC

12-16-2) **(before its repeal);** and

(B) the denominator is the total amount of the provider's patient revenues paid to the provider, including cash subsidies; and

(2) A fraction (expressed as a percentage) for which:

(A) the numerator is the total amount of the provider's charges for inpatient services that are attributable to care provided to individuals who have no source of payment; and

(B) the denominator is the total amount of charges for inpatient services.

(b) The numerator in subsection (a)(1)(A) does not include contractual allowances and discounts other than for indigent patients not eligible for Medicaid.".

Page 12, line 26, delete "JANUARY 1, 2001" and insert "JULY 1, 2000".

Page 12, line 42, delete "for the period before January 1, 2001," and insert "**for the state fiscal years ending on or before June 30, 2000**".

Page 13, delete lines 4 through 28.

Page 13, line 29, delete "(C)" and insert "**(B)**".

Page 13, line 31, delete "2001" and insert "**2000**".

Page 13, line 35, delete "IC 12-15-15-1.1" and insert "**IC 12-15-15-1.1(b)**".

Page 14, line 7, delete "clauses" and insert "**clause**".

Page 14, line 7, delete "and (C)".

Page 14, line 9, delete "disproportionate" and insert "**Medicaid add-on payments to hospitals licensed under IC 16-21 pursuant to a payment methodolgy developed by the office.**".

Page 14, delete line 10, begin a new paragraph and insert:

"SECTION 13. IC 12-15-41 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 41. Annual Review of Medicaid Nursing Facility Residents

Sec. 1. "Minimum data set" or "MDS" means a core set of screening and assessment elements, including common definitions and coding categories, used as:

(1) a comprehensive assessment for all residents of long term care facilities certified to participate in the Medicaid program; and

(2) a standardized communication about resident problems, strengths, and conditions within the facilities, between facilities, and between facilities and outside agencies.

Sec. 2. A nursing facility certified to provide nursing facility care to Medicaid recipients shall submit to the office annually minimum data set (MDS) information for each of its Medicaid residents.

Sec. 3. (a) The office or the office's designated contractor shall evaluate the MDS information submitted for each Medicaid resident. The evaluation must consist of an assessment of the following:

(1) The individual's medical needs.

(2) The availability of services, other than services provided in a nursing facility, that are appropriate to the individual's needs.

(3) The cost effectiveness of providing services appropriate to the individual's needs that are provided outside of, rather than within, a nursing facility.

(b) The assessment must be conducted in accordance with rules adopted under IC 4-22-2 by the office.

Sec. 4. If the office determines under section 3 that an individual's needs could be met in a setting other than a nursing facility and in a cost effective manner, the office shall counsel the individual and provide the individual with written notice containing the following:

(1) The reasons for the office's determination.

(2) A detailed description of services available to the individual that, if used by the individual, make the continued placement of the individual in a nursing facility inappropriate.".

Page 14, line 16, delete "2001" and insert "**2002**".

Page 16, line 22, delete "under" and insert "**by**".

Page 16, line 23, delete ":" and insert "**,**".

Page 16, line 24, delete "(1)".

Page 16, line 27, delete "; and" and insert "**.**".

Page 16, run in lines 23 through 27.

Page 16, delete line 28.

Page 16, between lines 28 and 29, begin a new paragraph and insert:

"SECTION 19. IC 12-16.1 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]:

ARTICLE 16.1. HOSPITAL CARE FOR THE INDIGENT

Chapter 1. Applicability

Sec. 1. This article applies only if the office of the uninsured parents program established by IC 12-17.7-2-1 does not implement

an uninsured parents program before July 1, 2003.

Chapter 2. Administration and General Provisions

Sec. 1. The division shall administer the hospital care for the indigent program under this article.

Sec. 2. The division shall adopt necessary forms to be used by the patients, hospitals, physicians, and county offices in carrying out the hospital care for the indigent program.

Sec. 3. The following persons have the same rights and obligations with respect to the hospital care for the indigent program as the persons have with respect to the Medicaid program under IC 12-15-8 and IC 12-15-29:

(1) The division.

(2) Applicants and recipients of assistance.

(3) Insurers.

(4) Persons against whom applicants and recipients of assistance have claims.

(5) The office of Medicaid policy and planning.

Sec. 4. To the extent permitted under federal statutes or regulations, patient days for patients under the hospital care for the indigent program shall be included in calculating allowable disproportionate share additional payments under 42 U.S.C. 1395ww(d).

Sec. 5. The hospital care for the indigent program does not apply to inmates and patients of institutions of the department of correction, the state department of health, the division of mental health, or the division of disability, aging, and rehabilitative services.

Chapter 3. Eligibility for Assistance

Sec. 1. (a) An Indiana resident who meets the income and resource standards established by the division under section 3 of this chapter is eligible for assistance to pay for any part of the cost of care provided in a hospital in Indiana that was necessitated after the onset of a medical condition that was manifested by symptoms of sufficient severity that the absence of immediate medical attention would probably result in any of the following:

(1) Placing the individual's life in jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of a bodily organ or part.

(b) A qualified resident is also eligible for assistance to pay for the part of the cost of care that is a direct consequence of the medical condition that necessitated the emergency care.

Sec. 2. (a) An individual who is not an Indiana resident is

eligible for assistance to pay for the part of the cost of care provided in a hospital in Indiana that was necessitated after the onset of a medical condition that was manifested by symptoms of sufficient severity that the absence of immediate medical attention would probably result in any of the following:

(1) Placing the individual's life in jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(b) An individual is eligible for assistance under subsection (a) only if the following qualifications exist:

(1) The individual meets the income and resource standards established by the division under section 3 of this chapter.

(2) The onset of the medical condition that necessitated medical attention occurred in Indiana.

Sec. 3. (a) The division shall adopt rules under IC 4-22-2 to establish income and resource eligibility standards for patients whose care is to be paid for under the hospital care for the indigent program.

(b) To the extent possible, rules adopted under this section must meet the following conditions:

(1) Be consistent with IC 12-15-21-2 and IC 12-15-21-3.

(2) Be adjusted at least one (1) time every two (2) years.

(c) The income and eligibility standards established under this section do not include any spend down provisions available under IC 12-15-21.

(d) In addition to the conditions imposed under subsection (b), rules adopted under this section must exclude a Holocaust victim's settlement payment received by an eligible individual from the income and eligibility standards for patients whose care is to be paid for under the hospital care for the indigent program.

Sec. 4. A hospital shall provide a patient and, if the patient is not able to understand the statement, the patient's representative with a statement of the eligibility and benefit standards adopted by the division if at least one (1) of the following occurs:

(1) The hospital has reason to believe that the patient may be indigent.

(2) The patient requests a statement of the standards.

Chapter 4. Application for Assistance

Sec. 1. To receive payment from the division for the costs incurred in providing care to an indigent person, a hospital must file an application with the county office of the county in which the hospital is located.

Sec. 2. A hospital must file the application with a county office not more than thirty (30) days after the patient has been admitted to the hospital, unless the patient is medically unable to sign the application and the next of kin or legal representative of the patient is unavailable.

Sec. 3. The division shall adopt rules under IC 4-22-2 prescribing the following:

(1) The form of an application.

(2) The establishment of procedures for applications.

(3) The time for submitting and processing claims.

Sec. 4. The division and a county office shall make application forms available to a hospital upon request.

Sec. 5. A hospital or an attending physician may assist the patient in the preparation of an application for assistance under the hospital care for the indigent program.

Sec. 6. A person who in good faith provides assistance in the completion of an application under this chapter is immune from civil or criminal liability arising from the assistance.

Sec. 7. (a) A patient must sign an application if the patient is medically able to sign.

(b) If a patient is medically unable to sign an application, the patient's next of kin or a legal representative of the patient, if available, may sign the application.

(c) If no person under subsections (a) and (b) is able to sign the application to file a timely application, a hospital representative may sign the application instead of the patient.

Sec. 8. (a) A patient may file an application directly with the county office in the county where the hospital providing care is located if the application is filed not more than thirty (30) days after the patient's admission to the hospital.

(b) Reimbursement for the costs incurred in providing care to an eligible person may only be made to the providers of the care.

Chapter 5. Eligibility Determinations; Investigations

Sec. 1. A county office shall, upon receipt of an application of a patient admitted to a hospital, promptly investigate to determine the patient's eligibility under the hospital care for the indigent program.

Sec. 2. (a) The hospital providing medical care to a patient shall provide information the hospital has that would assist in the verification of indigency of a patient.

(b) A hospital that provides information under subsection (a) is immune from civil and criminal liability for divulging the

information.

Sec. 3. If the division or county office is unable, after prompt and diligent efforts, to verify information contained in the application that is reasonably necessary to determine eligibility, the division or county office may deny assistance under the hospital care for the indigent program.

Sec. 4. The division or county office shall notify, in writing, the patient and the hospital of the following:

(1) A decision concerning eligibility.

(2) The reasons for a denial of eligibility.

(3) That either party has the right to appeal the decision.

Chapter 6. Denial of Eligibility; Appeals; Judicial Review

Sec. 1. If the division or county office determines that a patient is not eligible for payment of medical or hospital care, an affected person may appeal to the division not later than ninety (90) days after the mailing of notice of that determination to the affected person at the person's last known address.

Sec. 2. If the division or county office:

(1) fails to complete an investigation and determination of eligibility under the hospital care for the indigent program within forty-five (45) days after the receipt of the application filed under IC 12-16.1-4; or

(2) fails or refuses to accept responsibility for payment of medical or hospital care under the hospital care for the indigent program;

a person affected may appeal to the division not more than ninety (90) days after the receipt of the application filed under IC 12-16.1-4.

Sec. 3. The division shall fix a time and place for a hearing before a hearing officer appointed by the director of the division.

Sec. 4. A notice of the hearing shall be served upon all persons interested in the matter at least twenty (20) days before the time fixed for the hearing.

Sec. 5. (a) Following the hearing, the division shall determine the eligibility of the person for payment of the cost of medical or hospital care under the hospital care for the indigent program.

(b) If the person is found eligible, the division shall pay the reasonable cost of the care to the persons furnishing the care, subject to the limitations in IC 12-16.1-7.

Sec. 6. A person aggrieved by a determination under section 5(a) of this chapter may appeal the determination under IC 4-21.5.

Sec. 7. (a) The division shall adopt rules under IC 4-22-2 that

provide for an administrative appeal procedure that is responsive to the needs of patients and providers.

(b) The procedure must provide for the following:

(1) The location of hearings.

(2) The presentation of evidence.

(3) The use of telecommunications.

Chapter 7. Cost of Care and Payment

Sec. 1. The division shall pay the following, subject to the limitations in section 4 of this chapter:

(1) The necessary costs of medical or hospital care for indigent patients.

(2) The cost of transportation to the place of treatment arising out of the medical or hospital care for indigent patients.

Sec. 2. (a) Except as provided in section 5 of this chapter, claims for payment shall be segregated by year using the patient's admission date.

(b) Each year, the division shall pay claims as provided in section 4 of this chapter without regard to the county of admission or that county's transfer to the state fund.

Sec. 3. A payment made to a hospital under the hospital care for the indigent program must be on a warrant drawn on the state hospital care for the indigent fund established under IC 12-16-14.

Sec. 4. (a) Each year, the division shall pay two-thirds (2/3) of each claim upon submission and approval of the claim.

(b) If the amount of money in the state hospital care for the indigent fund in a year is insufficient to pay two-thirds (2/3) of each approved claim for patients admitted in that year, the state's and a county's liability to providers under the hospital care for the indigent program for claims approved for patients admitted in that year is limited to the sum of the following:

(1) The amount transferred to the state hospital care for the indigent fund from county hospital care for the indigent funds in that year under IC 12-16.1-14.

(2) Any contribution to the fund in that year.

(3) Any amount that was appropriated to the state hospital care for the indigent fund for that year by the general assembly.

(4) Any amount that was carried over to the state hospital care for the indigent fund from a preceding year.

(c) This section does not obligate the general assembly to appropriate money to the state hospital care for the indigent fund.

Sec. 5. Before the end of each state fiscal year, the division shall,

to the extent there is money in the state hospital care for the indigent fund, pay each provider under the hospital care for the indigent program a pro rata part of the one-third (1/3) balance on each approved claim for patients admitted during the preceding year.

Sec. 6. If:

(1) a claim for a patient admitted during a particular year is not submitted by the deadline established by the division; and

(2) the failure to submit the claim is not the fault of the provider;

the claim shall be considered a claim for the year the claim is submitted for purposes of payment under this chapter.

Sec. 7. The division and a county office are not responsible under the hospital care for the indigent program for the payment of any part of the costs of providing care in a hospital to an individual who is not either of the following:

(1) A citizen of the United States.

(2) A lawfully admitted alien.

Sec. 8. The division and a county office are not liable for any part of the cost of care provided to an individual who has been determined to be a patient described in the rules adopted under IC 12-16.1-10.

Sec. 9. IC 12-16.1-2 through IC 12-16.1-16 do not affect the liability of a county with respect to claims for hospital care for the indigent for patients admitted before January 1, 1987.

Sec. 10. (a) The budget agency shall estimate for each fiscal year the cost savings to the state hospital care for the indigent fund as the result of the provision of Medicaid to an individual described in IC 12-15-2-12 and IC 12-15-2-13.

(b) The budget agency shall, each fiscal year, recommend to the general assembly that an amount equal to the cost savings described in subsection (a) be transferred from the state hospital care for the indigent fund to the state general fund.

Sec. 11. Providers eligible for payment under IC 12-15-15-9 may not receive payment under this chapter.

Sec. 12. All providers receiving payment under this chapter agree to accept, as payment in full, the amount paid for the hospital care for the indigent program for those claims submitted for payment under the program, with the exception of authorized deductibles, co-insurance, co-payment, or similar cost sharing charges.

Chapter 8. Disproportionate Share Providers

Sec. 1. As used in this chapter, "inpatient days" includes:

(1) days provided by an acute care subunit of the provider; and

(2) inpatient days attributable to Medicaid and hospital care for the indigent beneficiaries from other states.

Sec. 2. A payment adjustment consisting of an additional percentage payment for each service paid under the hospital care for the indigent program made to a disproportionate share hospital licensed under IC 16-21 that meets the requirements under section 3 of this chapter.

Sec. 3. A provider is a disproportionate share hospital if the provider's Medicaid inpatient utilization rate is at least one (1) standard deviation above the mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana.

Sec. 4. A provider's Medicaid inpatient utilization rate is a fraction (expressed as a percentage) in which:

(1) the numerator is the provider's total number of Medicaid and health care for the indigent inpatient days in a cost reporting period; and

(2) the denominator is the total number of the provider's inpatient days in that same period.

Sec. 5. A disproportionate share hospital must receive a twenty percent (20%) adjustment for each service.

Chapter 9. Rate of Payment

Sec. 1. The rate of payment for the services and materials provided by hospitals and physicians under the hospital care for the indigent program is the same rate as payment for the same type of services and materials under the rules adopted by the secretary under Medicaid.

Chapter 10. Rules

Sec. 1. The division shall, with the advice of the division's medical staff, the division of mental health, the division of disability, aging, and rehabilitative services, and other individuals selected by the director of the division, adopt rules under IC 4-22-2 to do the following:

(1) Provide for review and approval of services paid under the hospital care for the indigent program.

(2) Establish limitations consistent with medical necessity on the duration of services to be provided.

(3) Specify the amount of and method for reimbursement for services.

(4) Specify the conditions under which payments will be

denied and improper payments will be recovered.

Sec. 2. To the extent possible, rules adopted under section 1 of this chapter must be consistent with IC 12-15-21-2 and IC 12-15-21-3.

Sec. 3. The rules adopted under section 1 of this chapter must include rules that will deny payment for services provided to a patient after the patient is medically stable and can safely be discharged.

Sec. 4. (a) The division shall adopt rules under IC 4-22-2 necessary to establish a statewide collection system of data concerning the hospital care for the indigent program.

(b) The following data must be collected:

(1) Patient demographics.

(2) Types of services provided by hospitals.

(3) Costs of particular types of services provided by hospitals.

(c) A hospital that provides services under the hospital care for the indigent program shall file copies of all claims submitted under the program with the contractor engaged by the division to adjudicate claims.

Sec. 5. The division may adopt rules under IC 4-22-2 that are in addition to and consistent with the rules required to be adopted under IC 12-16.1-6 governing appeals brought under the hospital care for the indigent program to the division.

Chapter 11. Recovery of Payments by Division

Sec. 1. The division may recover amounts paid under the hospital care for the indigent program by the division from the following:

(1) A patient approved for assistance.

(2) A person legally responsible for those patients approved for assistance.

(3) The estate of the patient or person.

Sec. 2. The division is subrogated, to the extent of the assistance given by the division, to the rights that a patient receiving assistance under the hospital care for the indigent program has against any other person who is in any part liable for the illness or injury for which assistance was granted.

Chapter 12. County With Health and Hospital Corporation; Responsibility for Medical Cost

Sec. 1. This chapter applies to a county having a health and hospital corporation created under IC 16-22-8-6.

Sec. 2. The division is responsible for the emergency medical care given in a hospital to an individual who qualifies for assistance

under this chapter, subject to the limitations in IC 12-16.1-7.

Sec. 3. The hospital providing care shall transfer the patient to a hospital operated by the health and hospital corporation as soon as the attending physician determines that the patient's medical condition permits the transfer without risk of injury to the patient.

Sec. 4. (a) If a hospital owned by the health and hospital corporation is:

(1) unable to care for a patient; or

(2) unable to treat a patient at the time a transfer is requested by the hospital initiating treatment;

the hospital initiating treatment may continue to treat the patient until the patient's discharge.

(b) Subject to the limitations in IC 12-16.1-7, the division shall pay the costs of care.

Sec. 5. The division is not responsible for the following:

(1) The payment of nonemergency medical costs, except as provided under the hospital care for the indigent program.

(2) The payment of medical costs accrued at a hospital owned or operated by a health and hospital corporation, except for hospital care provided under this chapter to a person not residing in Marion County.

Chapter 13. Immunity

Sec. 1. A hospital, a physician, or an agent or employee of a hospital or physician that provides services in good faith under the hospital care for the indigent program is immune from liability to the extent the liability is attributable to at least one (1) of the following:

(1) The requirement that a patient be transferred under IC 12-16.1-12.

(2) The denial of payment under IC 12-16.1-10.

Sec. 2. Section 1(1) of this chapter does not limit liability for the determination that the patient's medical condition permits a transfer under IC 12-16.1-12.

Chapter 14. Property Tax Levy and Funds

Sec. 1. A county hospital care for the indigent fund is established in each county. The fund consists of the following:

(1) A tax levy on the property located in each county.

(2) The financial institutions tax (IC 6-5.5), motor vehicle excise taxes (IC 6-6-5), and commercial vehicle excise taxes (IC 6-6-5.5) that are allocated to the fund.

Sec. 2. (a) The tax required by section 1(1) of this chapter shall be imposed annually by the county fiscal body on all of the taxable

property of the county.

(b) The tax shall be collected as other state and county ad valorem property taxes are collected.

Sec. 3. Each county shall impose a hospital care for the indigent tax levy equal to the product of:

(1) the most recent hospital care for the indigent property tax levied by the county; multiplied by

(2) the statewide average assessed value growth quotient, using all the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for the year in which the tax levy under this section will be first due and payable.

Sec. 4. The state board of tax commissioners shall review each county's property tax levy under this chapter and shall enforce the requirements of this chapter with respect to that levy.

Sec. 5. All receipts derived from the tax levy shall be paid into the county general fund and constitute the county hospital care for the indigent fund.

Sec. 6. (a) The state hospital care for the indigent fund is established.

(b) Before the fifth day of each month, all money contained in a county hospital care for the indigent fund at the end of the preceding month shall be transferred to the state hospital care for the indigent fund.

Sec. 7. (a) The state hospital care for the indigent fund consists of the following:

(1) Money transferred to the state hospital care for the indigent fund from the county hospital care for the indigent funds.

(2) Any contributions to the fund from individuals, corporations, foundations, or others for the purpose of providing hospital care for the indigent.

(3) Money advanced to the fund under IC 12-16.1-15.

(4) Appropriations made specifically to the fund by the general assembly.

(b) This section does not obligate the general assembly to appropriate money to the state hospital care for the indigent fund.

Sec. 8. The division shall administer the state hospital care for the indigent fund and shall use the money currently in the fund to defray the expenses and obligations incurred by the division for hospital care for the indigent. The money in the fund is hereby appropriated.

Sec. 9. Money in the state hospital care for the indigent fund at

the end of a state fiscal year remains in the fund and does not revert to the state general fund.

Chapter 15. Advancements From State Fund

Sec. 1. The division may request an advancement of money from the state general fund in anticipation of county property tax revenue being transferred to the state hospital care for the indigent fund.

Sec. 2. (a) The budget director shall determine an interest rate that is at least the interest rate earned by the state on investments made from money in the state general fund.

(b) The interest rate shall be paid on the amount that is advanced from the state general fund.

Sec. 3. The amount that may be advanced, plus the projected interest on that amount, may not exceed the amount of county property tax revenue that is expected to be transferred to the state hospital care for the indigent fund during the six (6) months following the date of the request.

Sec. 4. A request for an advancement must be submitted to the budget agency.

Sec. 5. The state board of finance may, on the recommendation of the director of the budget agency, approve an advancement.

Sec. 6. If an advancement is approved, the county property tax revenue transferred to the state hospital care for the indigent fund shall be immediately used to repay the amount of the interest and advancements made under this section.

Chapter 16. Review of Medical Criteria

Sec. 1. The division shall review changes made after 1985 in the medical criteria used to establish whether a patient is eligible for assistance under IC 12-16.1-3.

Sec. 2. The division's review under this chapter must include the application of the criteria to specific cases and address whether changes to or clarification of the criteria is necessary so that, in practice, the criteria are consistent with the hospital care for the indigent program.

Sec. 3. The division shall provide to an interested party a report of the division's review, including the division's findings, conclusions, and recommendations.".

Page 16, between lines 35 and 36, begin a new paragraph and insert:

"**Sec. 2. (a) "Caretaker relative" means a blood relative and those of half blood.**

(b) The term includes an adoptive parent, grandparent, sibling, and a relative of an adoptive parent.

(c) The term also includes a spouse of an individual described in subsection (b), even after the marriage is terminated by death or dissolution.".

Page 16, line 36, delete "2." and insert "**3.**".

Page 17, line 5, delete "3." and insert "**4.**".

Page 17, line 7, delete "4." and insert "**5.**".

Page 18, line 21, delete "parent" and insert "**caretaker relative**".

Page 19, between lines 30 and 31, begin a new paragraph and insert:

"**Sec. 4. (a) The office shall offer health insurance coverage for the following additional services if the coverage for the services has an actuarial value equal to or greater than the actuarial value of the services provided by the benchmark program determined by the children's health policy board established by IC 4-23-27-2:**

(1) Prescription drugs.

(2) Mental health services.

(3) Vision services.

(4) Hearing services.

(5) Dental services.

(b) The office may not impose treatment limitations or financial requirements on the coverage of services for a mental illness if similar treatment limitations or financial requirements are not imposed on coverage for services for other illnesses.".

Page 19, line 31, delete "4." and insert "**5.**".

Page 19, line 33, delete "5." and insert "**6.**".

Page 20, line 18, delete "has" and insert "**shall have**".

Page 22, line 5, delete "not" and insert "**only**".

Page 22, line 5, delete "any person" and insert "**the following:**

(1) Another provider involved or potentially involved in the care of the individual.

(2) A person who:

(A) works under the authority of a provider described in subdivision (1); and

(B) requires the information for the provider's legitimate business or clinical purposes.".

Page 22, between lines 15 and 16, begin a new paragraph and insert:

"**Sec. 1. This chapter applies beginning July 1, 2002.**".

Page 22, line 16, delete "1" and insert "**2**".

Page 22, line 29, delete "2" and insert "**3**".

Page 22, line 29, delete "1(a)(1)" and insert "**2(a)(1)**".

Page 22, line 34, delete "1(a)(1)" and insert "**2(a)(1)**".

Page 22, line 37, delete "3" and insert "**4**".

Page 22, line 37, delete "sections 4 and 5" and insert "**sections 5**

and 6".

Page 22, line 37, delete "section 5" and insert "**section 6**".

Page 22, line 42, after "equal" insert "**ninety percent (90%) of**".

Page 23, line 9, after "equal" insert "**ninety percent (90%) of**".

Page 23, line 27, delete "4" and insert "**5**".

Page 24, line 14, delete "3(3)" and insert "**4(3)**".

Page 24, line 15, delete "5" and insert "**6**".

Page 25, line 2, delete "3(3)" and insert "**4(3)**".

Page 25, line 3, delete "6" and insert "**7**".

Page 25, line 6, delete "7" and insert "**8**".

Page 26, between lines 39 and 40, begin a new paragraph and insert:

"SECTION 26. IC 34-30-2-45.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: **Sec. 45.5. IC 12-16.1-4-6 (Concerning persons who aid a patient in completing an application for assistance under the hospital care for the indigent program).**

SECTION 27. IC 34-30-2-45.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: **Sec. 45.7. IC 12-16.1-5-2 (Concerning hospitals for providing information verifying indigency of patient).**

SECTION 28. IC 34-30-2-45.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JUNE 30, 2002]: **Sec. 45.9. IC 12-16.1-13-1 (Concerning hospitals or persons providing services under the hospital care for the indigent program).**".

Page 27, delete lines 19 through 23.

Page 27, line 24, after "19." insert "IC 12-10-12-27.1; IC 12-10-12-28.5".

Page 27, between lines 27 and 28, begin a new paragraph and insert:

"SECTION 30. THE FOLLOWING ARE REPEALED [EFFECTIVE JULY 1, 2002]: IC 12-7-2-118; IC 12-16-2; IC 12-16-3; IC 12-16-4; IC 12-16-5; IC 12-16-6; IC 12-16-7; IC 12-16-8; IC 12-16-9; IC 12-16-10; IC 12-16-11; IC 12-16-12; IC 12-16-13; IC 12-16-15; IC 12-16-16; IC 34-30-2-44; IC 34-30-2-45; IC 34-30-2-45.3.".

Page 27, line 28, delete "JUNE 30" and insert "JULY 1".

Page 27, delete lines 36 through 42.

Page 28, delete lines 1 through 3.

Page 28, between lines 26 and 27, begin a new paragraph and insert:

"**(e) Notwithstanding subsection (d), the office shall not in any event implement the state plan amendment and waiver:**

(1) before July 1, 2002; and

(2) before requisite funds for the program's implementation are available or projected to be available, as determined by the office.".

Page 28, line 27, delete "(e)" and insert "**(f)**".

Page 28, line 32, delete "(f)" and insert "**(g)**".

Page 28, line 41, delete "(g)" and insert "**(h)**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1727 as introduced.)

BAUER, Chair

Committee Vote: yeas 22, nays 1.